ACQUIRED IMMUNE DEFICIENCY SYNDROME EDUCATION AND TRAINING: EFFECTS ON SHELTER WORKERS' ATTITUDES TOWARD HOMELESS PERSONS WITH AIDS

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ABSTRACT

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Persons with AIDS have joined the ranks of the homeless as a result of housing evictions and loss of employment. For many of them, shelters are their only viable option. However, persons with AIDS have received negative treatment in shelters from shelter workers who are fearful of catching the disease. The purpose of this study was to determine the impact of AIDS education and training on three dimensions: knowledge, fear and moral judgement. This study examined the responses of 40 shelter directors and service providers to the Shelter Directors and Service Providers Survey immediately before and after a 60 minute educational program on AIDS. Survey respondents, representing 55 shelters in Atlanta, GA, were

primarily black females ranging in ages 20 to 65. T-tests and frequency analysis were computed for each of the dimensions. Results showed no significant differences between pre and posttest scores on all dimensions. Implications for shelter directors and social workers are also included.

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CHAPTER I

Introduction

Homelessness and Acquired Immune Deficiency Syndrome (AIDS) are social and bio-psychosocial problems respectively. While they are separate and distinct in some ways they are intertwined in others. Between the two conditions, the similarities are great. Since 1981, there has been a rapid increase in the number of homeless persons nationally, with estimates ranging from 192,000 to 735,000 ((U. S. Department of Housing and Urban Development (HUD), 1984; Alliance Housing Council, 1988).

The Centers for Disease Control has also estimated that one million to one and one half million people are now infected with the AIDS virus (Boffey, 1988). Both the homeless and AIDS populations consist not only of men, women, and children, but also of runaway teenagers and infants (Boxill and Beaty, in press; Hersch, 1988; Honey, 1988). In addition, the number of Blacks and minorities has been increasing among the homeless

Wright, 1988) and among people with AIDS (Joseph, 1988).

Fear of both groups, for different reasons, has appeared quite often in the literature. The public reaction to AIDS has even bordered on hysteria. In a Boston corporation, employees threatened to quit en masse if the company forced them to work with a person with AIDS (Conrad, 1986). Fear is not as prevalent regarding the general homeless population. However, it has existed in the past and to some extent it still does exist (Connell, 1987).

A moral and ethical factor that affects the people in both groups is the amount of discrimination they have received from the rest of society. Both conditions pose a great threat to the general population and, therefore, have been viewed as unpopular conditions. As a consequence, homeless persons with AIDS have suffered a double stigma. They have an infectious, possibly fatal, disease and are also without permanent housing. While there have been many deaths attributed to both conditions (Fabricant and Kelly, 1986), only AIDS is infectious and can be transmitted to another person.

Interventions have been offered for each group separately, but few have been created for the combined group. Governmental efforts have been made to respond to problems of homelessness (HUD, 1984). In addition, federal and philanthropic responses have been made to help AIDS victims (U. S. Department of Health and Human Services (USHHS), 1987). However, major policy decisions have not been formulated for the growing social problem of the group now referred to as "homeless persons with AIDS." Of those who have become homeless, many turn to the nation's growing number of emergency shelter facilities.

To meet the needs of the homeless population, shelter programs run by various church groups have proliferated during the 1980s (Price, 1987). The primary goal of people who work in shelters has been to provide temporary shelter and emergency services such as food and clothing.

Persons with AIDS are now a part of the homeless population and should be entitled to the same services as regular homeless individuals. However, shelter advocates fear that shelter staff, who consist mostly of volunteers from religious backgrounds, would panic

if they suspected a resident in the shelter had AIDS (A. Beaty, 1988). There is also a level of prejudice toward this population, especially by the traditional religious groups who feel that the disease is a punishment from God (Feldman and Johnson, 1986).

Persons carrying the AIDS virus have been found among the shelter population in most major urban areas. They are being discharged from hospitals with no where to go, and several hundred persons with AIDS languish in shelters for the homeless throughout the state of New York (Hayes, 1987).

The number of AIDS cases among the homeless appears to be increasing and, therefore, poses a problem to people who work in city shelters. Subsequently, literature and research reviewed on the following pages will examine: homelessness, AIDS, homeless persons with AIDS, education as an intervention, shelters and shelter workers, and attitudes found to be most prevalent among people who care for persons with AIDS.

Review of Literature

Homelessness

Homelessness in America has emerged, especially within the last decade, as a social problem of considerable depth and magnitude (Roth and Bean, 1985; Stoner, 1984; and Wright and Lam, 1987). Thus, data from research on persons described as homeless must be interpreted with caution. One should bear in mind, for example, the variations produced according to the definition of the population and the setting in which the research was conducted (McChesney, 1988).

Homelessness Defined

There is no correct definition of homelessness;, rather, different definitions occur in the literature. (Redburn and Buss, 1986). For example, HUD has defined the homeless as people in the streets who, in seeking shelter, have no alternative but to obtain it from a private or public agency (HUD, 1984). Yet, according to Bassuk (1984), homelessness is the final stage in a lifelong series of crises and missed opportunities. It is also the culmination of a gradual disengagement from supportive relationships.

Fischer and Breakey (1986) referred to this type of detachment as disaffiliation and viewed it as one of two universal aspects of homelessness. The second aspect, lack of adequate shelter, has been noted in the literature as a primary reason for homelessness (Anderson, 1987; Applebaum, 1988).

Homelessness also exists in many different forms and degrees. It has most often been based on the time period involved, the alternative shelter available, and the nature of the person's social contacts.

Rivlin's (1986) definition of the homeless has been divided into four categories. They are 1) the chronic homeless, 2) the periodic homeless, 3) the temporary homeless, and 4) the catastrophic homeless. The chronic homeless is a marginal type of person who's condition is associated with alcoholism and drug abuse, and the stereotypical winos, bums and "bag ladies." The periodic homeless are those who leave home by choice when pressures become intense, leading them to the shelter or the streets, but the home is still available when the tensions subside.

Temporary homelessness is more time-limited than the other forms. It is usually a response to a crisis

that arises such as a fire, hospitalization, a move from one community to another, or other similar situations. The assumption here is that the ability to create a home has not been threatened. Consequently, once the person leaves the hospital, he/she either returns to the damaged home, or locates a new one. While the person's roots may have been damaged they have not been destroyed.

The most catastrophic form of homelessness may involve the sudden and complete loss of home and roots through natural, economic, industrial, or interpersonal disasters. The trauma of the total devastation of social and physical supports is thought to have seriously threatened the recuperative powers of the people involved. Many persons with AIDS have experienced this type of homelessness.

There appears to be no generally agreed upon definition of homelessness in the literature. For the purpose of this study, homelessness is defined, by this author, as a condition wherein an individual has no place to stay on any given night or day and is forced to seek accommodations in a private or public operated shelter.

Estimates of Homelessness

National estimates of the number of homeless people, based on local studies, range from a low of 192,000 to a high of 586,000 (HUD, 1984). A more recent estimate of the number of homeless people in the United States calculates that on any given night, there are 735,000 homeless people (Alliance Housing Council, 1988). Several experts have argued that most estimates of homeless people are well below often-cited figures (Baxter and Hopper, 1981; Redburn and Buss, 1986; McChesney, 1988). A reason offered for the wide variations in the figures has been the difficulty in counting people who are without residence (Hombs and Snyder, 1982).

Causes of Homelessness

During the early 1980s, for the first time in almost a half century, homelessness came to the forefront as a public issue. Common causes for this national growing problem have been the rising rates of unemployment, lower wages, government cutbacks in welfare and lack of public housing (McChesney, 1988; Stoner, 1984; Kaufman, 1984). Fabricant and Kelly (1988) have also offered that the ranks of the homeless

have continued to grow each year as a result of deinstitutionalization of the mentally ill. Sloss (1984) and Applebaum (1988) and a host of others have also agreed with this assessment.

Rivlin (1986) disagreed that deinstitutionalization of the mentally ill is a major contributor to the ranks of the homeless. She has suggested that most people are forced into homelessness by poverty, elimination of social services, fires, or evictions.

The Homeless As A Heterogenous Population

The most distinctive feature of homelessness today is its heterogeneity and variety (Stoner, 1984). No longer do they fit the traditional stereotype of a single, middle-aged white alcoholic male. The homeless of today are younger, more ethnically diverse, and increasingly are more likely to be members of families (Alliance Housing Council, 1988). Among the new arrivals to the homeless population are women, children, and veterans from various backgrounds (Institute of Medicine, 1988).

Some homeless persons have chronic disabilities such as mental illness, alcoholism and other forms of substance abuse. They are persons who have experienced

severe personal crisis and who have suffered from adverse economic conditions (HUD, 1984).

Attitudes Toward the Homeless

The attitude that homelessness and moral depravity were causally related has existed for some years. In 1890, William Booth surveyed London's poorest citizens (Filardo, 1985). Besides making mention of a few specific disease statistics, he spoke at length of the wretched conditions in which he found the souls he wished to heal with his newly formed Salvation Army. When he discussed the East Londoners, Booth's tone was frequently judgmental as he reflected on the factors to count accurately the inmates of common lodging houses referred to as "homeless outcasts."

Traditionally, one of the most dominant responses to homeless people has been fear and avoidance behavior prompted by fear. Connell (1987) noted that homeless men on Skid Row tended to be treated by agents of society with intolerance, disgust, disrespect, fear, and apprehension. Yet, though Skid Rows have generally disappeared, these attitudes have persisted (Connell, 1987).

The social stigma associated with the residents of Skid Row areas was generalized as a social illness characterized by homelessness (Hoch, 1988). Although more socially diverse than their Skid Row predecessors, the new homeless share a similar kind of social marginnality that inspires professional scrutiny and compassion while encouraging public curiosity and contempt (Hock, 1988).

In conclusion, the homeless of today are more heterogenous than in earlier years, and reasons for their homelessness vary from study to study. One agreed upon fact is that the lack of low-income housing is the primary reason for homelessness in the decade of the 1980s. Whatever their definition, estimates, projected causes, or make-up, the number of homeless appear to be increasing.

The homeless of today experience an array of problems including that of poor health. Health problems and diseases have recently been included among the causes of homelessness. For example, a contemporary illness that has been found to lead to homelessness is Acquired Immune Deficiency Syndrome (AIDS).

Acquired Immune Deficiency Syndrome (AIDS)

Acquired Immune Deficiency Syndrome (AIDS) has become the most frightening, and potentially the most dangerous, infectious disease known. Although a cure is being sought, there is still only minimal understanding of its characteristics and its transmission (Langone, 1988).

Definition of AIDS

AIDS was first defined by the Centers for Disease Control (CDC) as a "reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has no known underlying cause of reduced resistance reported to be associated with that disease" (CDC, 1983). CDC's definition has been updated and refined as more has been learned about the disease and its clinical manifestations. The updated version, like the original one, is difficult for non-medical persons to comprehend. Therefore, simpler versions of the AIDS definition have been found in the literature.

For example, the U. S. Department of Labor has offered a simple, uncluttered and therefore easily understandable version adapted from CDC's definition.

AIDS is a disease caused by a virus that destroys the body's ability to fight off illness. AIDS by itself does not kill, but it allows other infections to invade the body, and these can be fatal. AIDS describes several characteristics of this disease. Acquired means that it is not caused by an inherited predisposition, but is a condition that develops as a result of exposure to something external to the body, the AIDS virus. Immune Deficiency indicates that the part of the body which AIDS weakens is the immune system, which normally protects one from the disease. Syndrome means that the disease results in a variety of health problems (U. S. Department of Labor, 1986).

The virus which causes AIDS is called the human immunodeficiency virus, or HIV (formerly called HTLV III/LAV). The AIDS virus attacks an individual's immune system and ultimately destroys the ability to ward off disease. Infection with HIV may result in a wide range of immunologic and clinical conditions (U. S. Department of Health and Human Services USDHHS), 1987). Among the diseases that indicate a diagnosis of AIDS are Kaposi's sarcoma (KS), Pneumocystis carinii pneumonia (PCP), and other opportunistic infections (CDC, 1984). Recently,

the CDC included severe weight loss, known as "wasting syndrome," and AIDS-related dementia with the presence of a positive human immunodeficiency virus (HIV) test finding as indicative of an AIDS diagnosis, even in the absence of a specified opportunistic infection (CDC, 1987).

Paradoxically, the virus is both potentially lethal once inside the body and remarkably fragile outside the body. It will not survive long outside a host cell and is, in fact, not dangerous outside a host cell. HIV is killed by diluted solution of household bleach (USDHHS, 1987).

Classifications of AIDS

Individuals infected with HIV may fall into one of several groups. Some may test positive, which indicates HIV exposure and seroconversion, but may remain asymptomatic and feel healthy. Others who test HIV-positive may have suppressed immune systems (reduced T-cells) and suffer from conditions such as persistent generalized lymphadenopathy (swollen lymph glands but do not harbor any opportunistic infections). These individuals were diagnosed as having AIDS Related Complex (ARC). Finally, some persons may test positive for HIV exposure,

have lowered T-cell ratios and one or more opportunistic infections, and thus be diagnosed as having AIDS (Robinson, 1984).

Information regarding AIDS is constantly being updated. For example, the individuals who were said to have ARC did not originally meet CDC's diagnostic criteria for AIDS (CDC, 1986). ARC symptoms have since been added to the definition of AIDS, which allows for previous so-called ARC patients to receive the same benefits as those individuals diagnosed as having AIDS (S. Cort, personal communication, January 16, 1988).

Transmission of AIDS

Human immunodeficiency virus (HIV), the virus that causes AIDS, is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission (CDC, 1987).

In the U. S. the major mode of the HIV transmission is sexual, both homosexual and heterosexual. The AIDS virus is transmitted primarily through direct blood-to-blood or semen to blood contact. Infected men depositing semen vaginally, anally, or orally may transmit the virus; infected women may transmit the virus as well (USDHHS, 1987).

In the case of blood, the virus is mainly spread by intravenous drug users sharing contaminated needles and syringes. Also, an infected pregnant woman can pass the virus to her child either before, during, or just after birth. For hemophiliacs or others receiving blood transfusion, screening of blood products has minimized the risk of exposure since April 1985 (CDC, 1988).

There are many unknown factors concerning AIDS and only circumstantial assumptions can be made about how the virus is transmitted (Feldman and Johnson, 1988). For example, other possible modes of AIDS transmission have included oral sex (swallowing semen, oral/anal contact), kissing (the exchange of saliva), sharing household items that may come into contact with blood

(i.e., toothbrushes or razors) and being bitten by infected insects (USDHHS, 1987).

Although the AIDS virus has been isolated in very small amounts in breast milk and tears in some AIDS patients, HIV is found in highest concentration in two bodily fluids: semen and blood (USDHHS, 1987). So far, there have been no documented cases of the virus being transmitted through saliva or the sole act of oral sex (T. Leonard, personal communication, June 12, 1989). There is also no evidence that HIV is transmitted by bites from insects. For example, studies have shown that mosquitos do not transmit HIV infection (USDHHS, 1987).

AIDS is not transmitted by the kind of nonsexual contact that generally takes place between workers and clients or consumers in the workplace. Therefore, the vast majority of workers have no risk of getting AIDS at their jobs. However, individuals who come into direct contact with blood or body fluids at their jobs, such as health-care workers, may risk exposure to the AIDS virus (U. S. Department of Labor, 1988).

Although semen and vaginal secretions have been implicated in the sexual transmission of HIV, they have

not been implicated in occupational transmission from patient to health-care worker. Occupational HIV infection has been documented, however, no AIDS case or AIDS-related death is believed to be occupationally related (CDC, 1987; U. S. Department of Labor, 1988).

Even in groups that presumably have high potential exposure to HIV-contaminated fluids and tissues, e.g., health-care workers specializing in the treatment of AIDS patients and the parents, spouses, children, or other persons living with AIDS patients, transmission is recognized as occurring only between sexual partners or as a consequence of mucous membrane or parenteral exposure to blood or other body fluids (CDC, 1988).

Regardless of how AIDS is transmitted, people seem to be so fearful of the very mention of AIDS that they either ignore or dismiss information on how the disease is transmitted. In addition, many people lack knowledge about AIDS and therefore express negative moral judgment toward persons with AIDS.

Incidence of AIDS

As of August 1, 1988, 69,000 cases of AIDS in the United States had been reported to CDC and of that number, 39,000 people had died of the disease (CDC,

1988). It has been predicted that by the end of 1991 almost 270,000 people will have contracted the AIDS virus. Of that number 179,000 will have died (USDHHS, 1987). Other people may remain in apparent good health and walk around with the virus and not even know it. Consequently, it is impossible to distinguish all persons with AIDS from non-AIDS persons. Therefore, it is important for people who work with this particular population to obtain AIDS education and training.

AIDS Population

When AIDS was first recorded in the United States in 1981 it was found to be epidemic in four groups: homosexual men, IV drug users, Haitians, and hemophiliacs (CDC, 1984). Because homosexual men made up the greatest percentage, most people thought of AIDS as a "Gay Plague," a terrifying disease that affected mainly white homosexual men. But as gay men changed their lifestyles in response to AIDS, the demographics of the disease shifted (Clarke and Potts, 1988). It is an accepted fact now that the AIDS virus does not discriminate on the basis of sexual preference. It can infect anyone who engages in sexual intercourse or IV

needle-sharing with an infected person (Pierce and VanDeVeer, 1988).

Attitudes toward AIDS

AIDS is strongly associated with behaviors which have been traditionally considered deviant. This is true for both homosexuality and intravenous drug use. After a generation of improved social tolerance for homosexuality, the epidemic has generated new fears and heightened old hostilities. Just as syphilis once created a disease oriented xenophobia in the early twentieth century, AIDS has today generated a new homophobia (Brandt, 1988).

AIDS has had a great impact on public attitudes toward victims of AIDS leading to many instances of overt discrimination, social ostracism, and even the deprivation of various rights such as housing, employment, transportation, and funeral services (Leo, 1983). Recent surveys have indicated the stigmatizing of persons with AIDS is related to fear of contagion or prejudice against homosexuals or to a combination of these factors such as lack of knowledge and negative moral judgment. Although a cure is being sought, there

is still only minimal understanding of its characteristics and its transmissions.

Until mid-1980s, AIDS posed little threat to the general population. It is now considered a threat to anyone in the population who engages in any of the behaviors which are associated with the transmission of the AIDS virus (S. Cort, 1988). CDC has repeatedly declared that AIDS is not transmitted by casual contact. (Selby, 1984). Nevertheless, many people have continued to experience excessive fear of exposure to it. It has been suggested that the popular perception of AIDS as a "gay disease" continues to cause much of the hysteria that surrounds the disease.

AIDS will continue to elicit fear in people until it is understood, preventable, and treatable (Nichols and Ostrow, 1984). At present there is no cure for AIDS and there is no vaccine to prevent it (Koop, 1987). In the absence of vaccines, education is the best protection and is imperative as a precautionary measure. In addition, education is a vehicle by which to change attitudes.

Homeless Persons with AIDS

Homelessness and AIDS are major social and health problems of the 1980s which have reached epidemic proportions in the United States. As a result of the merging of these problems, there is a population now known as Homeless Persons with AIDS. This is such a new group that little reference has been made to it in the literature. Consequently, there is an extreme paucity of literature in this area. However, a recent article stands out as being one of the few pieces of literature devoted to this issue (Froner, 1988).

Origin of Homelessness and AIDS

Persons with AIDS began to join the ranks of the homeless when many were released from hospitals with no home to which they could return. In a recent New York Times article, (Baker, Johnson, Harrison, Cerio, Gordon, and Hutchinson, 1988), a spokesperson for the Partnership for the Homeless claimed that activists had warned, from the epidemic's outset, that the AIDS and homeless crises would intersect. It was also noted in that article that intravenous drug users, mostly Black and one of the two major AIDS-risk groups, accounted for a large percentage of the homeless. When the virus

first ravaged the gay community, white middle-class men began losing jobs and apartments without legal recourse (Clarke and Potts, 1988). Afraid to reveal their homosexuality to their families, or rejected when they did, persons with AIDS often wound up homeless (Boffey, 1988).

Homelessness has become a problem for many patients with AIDS, as well as for the health care provisions system in our nation's cities. Increasing numbers of AIDS patients have remained hospitalized solely because of homelessness, and others are inappropriately discharged to shelters or the streets (Torres, 1987).

Incidence and Causes

It has been difficult to provide even a close estimate of the number of homeless people with AIDS or ARC due to the extreme reluctance to reveal their disease status. However, rough estimates have been made in some cities. Officials in the two cities hit hardest by the AIDS epidemic estimated that there were 900 homeless AIDS sufferers in New York City and 200 to 400 in San Francisco in the early part of 1988 (Baker, et al., 1988; Froner, 1988). At that time, New York offered adequate housing to only 82 persons and San

Francisco had housing for only 91 persons (Baker et al., 1988). The rest lived and died on the streets, took up space in hospitals or lived in city shelters because they had nowhere to go (Joseph, 1988).

The reasons for homelessness among persons with AIDS and AIDS Related Complex (ARC) are primarily two-fold (W. Nidifer, personal communication, February 17, 1988). First, persons with AIDS lose their jobs and income due to health reasons or discrimination, frequently leaving no alternative but life on the streets. Second, people known to have AIDS and ARC are at increased risk for being evicted from their homes by landlords who are fearful of the disease and its impact on the rentability of their property.

Although patients with AIDS or ARC are not officially discharged from hospitals to shelters, people with AIDS who are evicted from their apartments or rooms may seek living accommodations within the shelter system (Joseph, 1988). Torres (1987) found that 13 percent of the 213 AIDS patients diagnosed at St. Vincent Hospital between 1981 and 1985 were identified as homeless upon admission. Also, another group of homeless individuals with AIDS or ARC may have developed these conditions

without episodes of hospitalization and therefore are part of an unofficial or "hidden" infected population (Partnership for the Homeless, 1988).

The Effect of Shelters on Persons with AIDS

Shelters pose numerous hazards to health and safety even for those without impaired immune systems. They are especially inappropriate for people infected with the AIDS or the AIDS virus. For instance diarrhea, which afflicts many people with AIDS, is especially distressing in a shelter setting. The afflicted have to get up in the dark and stumble over people in an effort to get to the toilet in a hurry. In addition, many diarrheal illnesses are prevalent in such settings and are transmitted to shelter users (Gross and Rosenberg, 1987).

A person with AIDS who has become homeless has fewer options than the general homeless population. While the latter population can survive for some time on the streets, in the subways, or in the transportation terminals, congregate shelters are not a viable alternative for an AIDS persons who is homeless (Partnership for the Homeless, 1988). For example, having a severely lowered immune system substantially increases the

probability of life-threatening infections from opportunistic diseases such as Tuberculosis (TB). TB is on the upsurge among the general shelter population (CDC, 1987). In addition to possible exposure to TB and other contagious diseases, people with AIDS who stay in shelters are vulnerable to theft, not only of money, but also of medication (Froner, 1988). Until separate facilities are made available for homeless persons with AIDS, the city shelters are their only viable option.

Attitudes toward homeless persons with AIDS

Homeless persons with AIDS suffer from the same stigmatizing attitudes as non-homeless people with the disease. Hayes (1987), who referred to homelessness and AIDS as twin plagues, has stated that a person with AIDS bears the cruel and misguided stigma of a modern day leper. For example, people have been refused admittance to shelters because they had AIDS. The way homeless persons with AIDS, who may use shelter services, are perceived and understood will determine how they are treated by shelter staff and what services will be offered them.

As stated earlier, AIDS has evoked highly emotional fears among the general public which has resulted in

irrational responses (Boffey, 1988). Homeless people with AIDS not only receive negative treatment from the public in general, they also encounter this same type of treatment in shelters where they tend to frequent because of their homeless condition (Kolata, 1988).

Shelters and Shelter Workers

The problem of homelessness is a profound and growing one in America. In addition, increasing numbers of AIDS patients stay in hospitals that cannot release them because they have nowhere to go (Baker et al, 1988). Because homeless persons with AIDS are not adequately served by the existing network of social programs, emergency shelters are often the only alternative to the streets.

Emergency Shelters

Shelters have been the nation's primary response to the demise of traditional arrangements for housing the ill, the infirm, and the very poor (Schutt, 1987). According to the HUD report published in 1984, there were over 1,800 shelters in the United States, which housed approximately 69,000 people (HUD, 1984). Currently in New York City, about 32,000 persons reside

in emergency shelters and temporary housing provided by the Human Resources Administration of New York City and non-profit groups (Joseph, 1988).

Many of the shelters started during the Depression and grew out of the altruistic traditions of rescue missions and church groups (Lamb, 1984). A decade ago, operating and funding shelters for the homeless was almost entirely the domain of private religious and other charitable institutions. In major urban areas, the public sector is, for the first time, involved in providing and coordinating shelter and other services for the homeless (Redburn and Buss, 1986). Public shelters came into being after a protracted struggle between concerned citizens and public officials (Hope and Young, 1986).

Private non-profits have been the major providers of assistance to homeless families in most cities. Non-profit private groups operate over 90 percent of all shelters, religious organizations operate about 40 percent, while non-religious groups run the rest (HUD, 1984). A large proportion of the existing services for the homeless rely on efforts of volunteers.

It is necessary to recognize that emergency shelters, while a necessary short-term palliative, are far from a desirable solution to the problem of homelessness in general, and homeless persons in particular (Applebaum, 1986). Even the best of shelters offer no substitute for housing (Dinkins and Wackstein, 1986). However, until the housing problem is solved, emergency shelters are the only recourse for the many homeless people with AIDS (Beaty, 1988).

Extent of AIDS in the shelters

Although the number of homeless AIDS or ARC patients is unknown, many have been forced to use the city shelters. According to Hayes (1987), there are several hundred persons with AIDS who live in New York city shelters. They conceal their conditions, however, since many fear they will be intimidated and threatened with physical violence if their health status should become known to other shelter residents. In one New York shelter, a man known to have AIDS, was beaten by residents and thrown out of the shelter (Kolata, 1988). In other cities, although space is sometimes available, people with AIDS have been denied entry to shelters (Morris, 1988).

Shelter Workers

Typical shelter workers are volunteers who generally are non-medical and often come from part of the Christian community. Shelters depend very heavily upon these types of volunteers (McChesney, 1988). This finding is similar to Hope and Young (1986), who surveyed city shelters and found them to be serviced by professionals, workers with quasi-professional inservice training, and volunteers, especially people with a religious commitment.

The level of volunteerism among New Yorkers of all social classes, seeking to do something about the homeless problem, is astonishingly high. For example, 126 different churches and synagogues throughout the city have established homeless shelters in their basements, each serving about ten people, each staffed entirely by citizen volunteers (Dinkins and Wackstein, 1986).

Volunteers come from various walks of life. Most have never before been involved in social service programs and few have prior experience assisting homeless people. Understandably, they sometimes feel overwhelmed by the problems and needs of the homeless.

This is especially true of those needs that go beyond the provision of temporary shelter and human comfort such as health problems. AIDS is a case in point.

Shelter staff workers are oftentimes terrified of catching some dread disease from the clients and bringing it home to their families. Such fears are not groundless, though they tend to be exaggerated (Baxter and Hopper, 1981). The list of afflictions commonly found in shelters include lice, TB, hepatitis, and a variety of respiratory ailments. AIDS has recently been added to this list. Persons with AIDS, unlike persons who may return to the work force, often become long-term shelter users. Moreover, this situation creates a great deal of occupational stress among shelter staff, who must deal with untenable and often, seemingly, hopeless circumstances (USDHHS, 1987).

Attitudes of Shelter Workers

Occasional eruptions of violence have led staff personnel to see the clients as uniformly unpredictable and dangerous. There have been instances of a supposedly gentle wino going berserk and attacking a staff member or guard (Baxter and Hopper, 1981). In several of the city shelters, references have been made

to the high prevalence of sexual assaults against homeless women (Institute of Medicine, 1988).

The emergence of AIDS among the homeless population has caused anxiety among people residing in emergency shelters. The majority of the shelter respondents, participating in a New York survey (Streuning and Pittman, 1987), were concerned about the consequence of the AIDS epidemic. Fifty-five percent of them were worried about getting AIDS. It is interesting to note that the focus of this study was shelter residents rather than shelter staff. With the exception of this study, there does not appear to have been any other literature exploring the attitudes of shelter residents or personnel toward persons with AIDS patients. In addition, knowledge regarding precautionary measures for shelter staff is also missing from the literature.

The acceleration of the incidence of AIDS among the homeless poses many questions for shelter staff workers. Factors include the management of fear and anxiety, and protection of staff and residents. Consequently, it is important to address these issues

among shelter workers in light of the expected increase.

The Need for Education

It is essential that AIDS education and training be made available to deal with the attitudes of shelter personnel toward persons with AIDS. The issue of shelter workers' attitudes toward AIDS and AIDS patients is important for a number of reasons. Those who work with the shelter population are a segment of the general population and share many of the community's social attitudes and stereotypes. To the extent that fear and stigmatizing attitudes relating to persons with AIDS exist, they may affect a worker's desire to continue working in shelters. At the very least, the quality of care may be limited. This phenomenon has been observed with respect to medical students' attitudes toward AIDS patients in a hospice (Feldman and Johnson, 1986).

Health care providers, who are potentially exposed to being splashed with blood or stuck with a needle, have reason to be concerned that infection-control precautions are implemented. Macks (1988) has recently suggested that practitioners who provide other than

medical care to persons with AIDS also need to be familiar with infection-control precautions. Therefore, it would appear that AIDS training regarding precautionary measures should be provided to those who work in shelters where at risk behaviors are known to occur.

Education as an Intervention

From the time it was determined that AIDS was communicable through certain "at risk" behaviors (intimate sexual contact and sharing intravenous (IV) needles), the principal public health strategy for limiting the spread of the disease has been education. This strategy has generally included dissemination of information concerning those sexual practices implicated in transmitting the AIDS virus (HIV) (Bauman and Siegel, 1987).

The most significant integrative effort to date in the general area of dissemination and utilization has been the work of Rogers (1962) on the diffusion of innovations. Rogers (1962) has defined diffusion as the process by which an innovation (i.e. idea, practice, or object) is communicated through certain chan-

nels over time among the members of a social system. Rogers has stated that the perceived newness of the idea for the individual determined his or her reaction to it. Therefore, if the idea seemed new to the individual, it was an innovation.

Rogers formulated and presented findings, primarily in terms of research problems directed toward interested social scientists, rather than practitioners or policymakers. In his review, many of those major efforts did not apply social science findings to organizations, work groups, classrooms, and so forth. Yet, as Lippitt (1977) has pointed out, generalizations derived from utilization attempts for physical and biological innovations may not be appropriate for social science utilizations.

The work of Rogers (1962) in many respects provided the model for Havelock (1977), whose review attempted to expand on Rogers' work. Havelock's (1977) investigation provided a framework for understanding the processes of innovation, dissemination, and knowledge utilization. His investigation reviewed the relevant literature in education and other fields of practice within this framework. Dissemination and

utilization (D&U) is viewed by Havelock (1977) as a transfer of messages by various media between resource systems and users. Deen (1981) has shown this with counsellor training, as has Kees-Martin and Christopher (1987) in dissemination of sex education by parent groups.

The Importance of AIDS Education

A pattern of discrimination against people known to, or even suspected of, being infected with HIV has emerged in employment, education, housing, health care and financial services. To eliminate this, AIDS education efforts have been recommended for persons who work in these areas (Ryan, 1986).

Significantly, as the number of new cases has continued to rise, the number of individuals with AIDS, who cannot be categorized into the "traditional" risk groups of gay or bisexual men and intravenous drug users, has also increased (Buckingham, 1987).

This has resulted in even greater public attention and concern. The news media, attentive to public interest in the disease, have become fixated on the AIDS crisis. They have often contributed to public misunderstanding of the disease almost to the point of

hysteria. For example, they have published repeated reports of the newest AIDS cases and the number of deaths associated with the disease (Conrad, 1986). Issues, such as the risk of contagion, sexual transmission, lack of medical knowledge, mortality rate, and social stigma, have culminated in a dramatic public interest in AIDS and a quest to determine who may be at risk.

In addition, it would appear that individuals who attempt to work with AIDS patients and HIV-positive persons must have a certain degree of self-awareness before dealing directly with these individuals. It has been suggested that clinicians and other caregivers confront their own prejudices and biases regarding infected patients, in order to fully respond to this crisis, so that they do not covertly undermine their own efforts (Buckingham, 1987; Kelly, 1987).

AIDS is the number one health concern in the United States. But in addition to that, it is a topic that is generally fraught with fear. From the start, AIDS has evoked highly emotional and often irrational responses. Much of the reaction can be attributed to fear of the many unknowns surrounding a new and very

deadly disease (Boffey, 1988). This fear is generally compounded by personal feelings regarding the groups of people primarily affected, who tend to be homosexual men and intravenous drug abusers.

According to Surgeon General Koop, others are not at risk for AIDS, if they follow recommended measures. However, in order to do that, they must be informed about them (Koop, 1987).

Several European countries have conducted massive media campaigns on AIDS, which have included leaflets and mass mailings. However, health officials in Great Britain thought a leaflet alone was insufficient to inform the public about AIDS (Bond, 1988). The United States' strategy was to disseminate information about the epidemic through an education brochure entitled "America Responds to AIDS." The brochure was mailed to 107 million households in the Spring of 1988. Yet, researchers such as Hostetler (1988) have stated that they were not sure how, or even if, America would respond to the brochure.

The Importance of AIDS Education in Shelters

The impact of AIDS is probably strongest where it is most vehemently denied or blamed on someone else. The denial can, not only be on the part of those at risk, but also on the part of those who come in contact with those at risk (McKusick, 1986). As the increasing number of persons with AIDS seek refuge in the city shelters, shelter workers will need to learn how to avoid exposure to the AIDS virus and how to treat victims of AIDS with dignity.

The recent literature has suggested there is a lack of AIDS training and education in shelters for the homeless, where residents and staff are at high risk for contracting the disease (Streuning and Pittman, 1988). Naturally, shelter directors have expressed concern for staff and residents in the event a person with AIDS is discovered living among the other shelter residents (A. Beaty, 1988).

Thus, people who operate the shelters have a fear of AIDS and may have preconceived negative moral judgments toward persons with AIDS. These attitudes, coupled with a lack of knowledge about AIDS, may interfere with the ways in which they serve this population.

There is good evidence that formally constituted leaders (administrators, supervisors, directors) do have a major effect on utilization of new ideas (Havelock, 1977).

As previously found in the literature (Bennett, 1987; Hayes, 1987, etc.), there is a need for education to reduce prejudice against persons with AIDS among those who are their caregivers. The need for AIDS education and training is a critical issue for shelter directors, because homosexual activity and intravenous drug use has occurred in some of the city shelters. Accurate information about HIV transmission and safety precautions may alter negative attitudes and alleviate fear of catching the disease.

Havelock (1977) stated that persons in positions of authority are the logical choices to be utilized as disseminators of information to subordinates. Therefore, it is of special importance that information regarding AIDS be disseminated in shelters, where "at risk" groups are known to reside (Joseph, 1988).

Attitude Theories

A vast array of literature exists on attitude theory (e.g., Pollock, 1986; Fishbein, 1967; Campbell, 1967). A definition of attitude that best fits the purpose of this research is that of Kerlinger (1984). He has described an attitude as an organized predisposition to think, feel, perceive, and behave toward a referent or cognitive object. He further stated that attitude is an enduring structure of beliefs that predisposes the individual to behave selectively toward attitude referents.

Kerlinger has defined a referent or cognitive object as being a category, class, or set of phenomena. Attitudes have several dimensions that have been suggested by the AIDS literature as knowledge, fear, and moral judgment (O'Donnell, O'Donnell, Pleck, Snarey, and Rose, 1987; Bohne, 1986; Temoshok, Sweet, and Zich, 1987).

Knowledge

A person's attitude toward his own conscious experience is ordinarily one of belief (Lee, 1973). While he viewed belief as an attitude, Lee (1973) has argued that knowledge is not to be defined as an atti-

tude; its distinguishing characteristic is evidence. He has further stated that beliefs are not necessarily propositional, but knowledge is propositional. When belief is of propositions, some evidence is necessary for justified belief, but it may not be sufficient to establish knowledge. Pollock, 1986), on the other hand, has stated that all information about the world is encapsulated in beliefs. In deciding what to believe, one cannot take account of anything except insofar as s/he has beliefs about it.

A common definition of knowledge is the act, fact, or state of knowing. Buchler (1955) has postulated four general ways of knowing or fixing belief. They are 1) the method of tenacity, 2) the a priori method, 3) the method of science, and 4) the method of authority.

The method of tenacity is one in which men hold firmly to the truth that they know to be true because they hold firmly to it, and because they have always known it to be true. The a priori method, also called the method of intuition, is a non-empirical, self-evident way of determining truth (Kerlinger, 1973).

The third method is the method of science and is determined largely by some external permanency, which involves what Peirce calls "real things" (Buchler, 1973). These are things whose characters have nothing to do with individualized opinions. The checks used in scientific research are anchored, as much as possible, in reality lying outside the scientist's personal beliefs, perceptions, biases, values, attitudes, and emotions (Buchler, 1955).

The fourth method, the method of authority, is one of established belief. For example, if the Bible says it, it is so, or if a noted psychiatrist says AIDS is God's punishment for homosexuals, it must be true. It is the method of authority that has particular relavance for the study of concept of knowledge. Information about AIDS and how it is transmitted is disseminated to the general public by people in positions of authority i.e., government agencies. Shelter directors and service providers are authority figures who can be viewed as disseminators of AIDS information to shelter staff.

To summarize, the assumption behind many theories on knowledge lies within the area of belief. However,

there appears to be some confusion in the literature as to the differentiation between knowledge and attitude. Authors have either combined or separated the two concepts. According to the definitions, and for the purpose of this study, knowledge is a component of attitude. This perspective is supported by Fishbein and Ajzen (1980), who have stated that attitudes are simple beliefs with an evaluative component.

The knowledge function of attitudes has been referred by Havelock (1977) as an individual's need for understanding and for meaningful cognitive organization. Of special importance is his finding that the attitude can be changed by a presentation of more meaningful information. This notion is supported by Zimbardo, Ebbesen, and Maslach (1977) who maintained that attitudes have been shaped by some specific training or education. As previously found in the literature, there is a need for education to reduce fear and prejudice against persons with AIDS (Bennett, 1987; Blumenfield, Smith, Milazzo, and Seropian, 1987).

Fear

Empirical studies of fear such as those of Fischer and Turner (1978), Grossberg and Wilson (1965), Wolpe and Lang (1964) have been dominated by psychologists and clinical practitioners. For the most part, fear and other emotions have been assigned to the psychological sciences. The prevailing attitude seems well expressed by Scherer (1982) who, along with most other theorists of emotion, has assumed that emotion (such as fear) is best treated as a psychological construct.

Scruton (1986) introduced sociophobics to the study of the phenomenon of fear. He has offered a fresh perspective on human fear and the act of fearing, which is sufficiently distinct from the current psychological approaches. It appears that Scruton's (1986) approach is sufficiently radical in its theoretical orientation, and possessed of sufficient potential for improving one's understanding of fear, that it merits consideration in this discussion.

For example, sociophobics is the study of human fears as these occur and are experienced in the context of the social cultural systems humans have created,

lived in, been shaped by, and reacted to for years. Scruton (1986) proposed that human fears are most efficiently understood as social phenomena.

According to Scruton (1986), fearing is a dimension of human social life. He has offered a number of broad categories in which fear seems to fall. They are physical fears, social fears, and fears for others. Under the category of physical fears, there are many anxieties which center on fear for one's physical self.

For example, there is a risk of contracting AIDS and suffering through the debilitating and disfiguring process, and/or the risk of getting ARC and suffering with symptoms as wasting away, etc. Such sudden threats to the integrity of one's physical fabric prompt fear, panic, terror.

Social fear is the category in which most fears fall. One example of social fear may include the mother who becomes anxious over the disclosure of her son's diagnosis of AIDS. In addition, she may worry that neighbors will not visit her, although her son no longer lives with her. Another example may be an

overweight person, who is afraid of losing weight, because others may think he has AIDS.

Much of one's fearing is not for self at all, but for others. Thus, these fears can easily reach or surpass the intensity of those for oneself. Any person, who has waited in silent misery, wondering about the outcome of a friend or family member being tested for HIV infection, conjuring dreadful images that could only be swept away if the test was negative, has experienced such a fear.

Additionally, a teacher, who must abide by the school rule which dictates that she must isolate a hemophiliac student with AIDS from the rest of the class, worries about the negative emotional impact on the student. The outcomes of such events as these do not involve injury or life's end. Nevertheless, the fear each person might experience is not felt less keenly because the outcomes are not life threatening.

Similarly, Gray (1971) has described a class of fear experiences he calls special evolutionary dangers. Individuals develop an innate fear towards a particular situation that is repeatedly responsible for the death of a significantly large proportion of

the members of a species over a sufficiently large span of time. The individuals of that species may fear some of the stimuli characteristic of that situation and try to avoid them. In this way, he accounts for what he regards as the innate human fear of snakes, and /or mutilated bodies. This may possibly include death and evil.

Loewy (1986) has defined fear as a sensation or a feeling of anxiety caused by a realization, perception or expectation of impotency in the face of perceived or expected danger or evil. Existing research has gen-rally focused on fear of contagion and fear of homo-sexuality as two prominent fears related to AIDS (Dunkel and Hatfield, 1986; Richardson et al., 1987).

Fear of disease

Hayes (1987) has referred to homelessness and AIDS as the twin plagues of our age. Plagues and mankind have shared an uneasy partnership ever since the first time a group of cave dwellers was wiped out by an epidemic (Marks, 1976). Cholera was the classic epidemic disease of the nineteenth century, as the plague had been for the fourteenth century. It surfaced as an epidemic in the United States in 1832,

1849, and again in 1866 (Rosenberg, 1962). Cholera, not unlike responses to plagues and epidemics throughout history, was preceded by warnings of evil and hallucinations born of fear.

Delaporte (1954) has described the response to cholera as one of massive fear; fear on the part of the lower classes that they were being poisoned, fear on the part of the upper classes that the way of life of the poorer and miserable classes provided a lethal breeding ground.

Because AIDS is almost always fatal and can be spread by persons having no visible symptom, it has produced what has been called a secondary epidemic, which is an "epidemic of fear" (Fettner and Check, 1984). Fear of AIDS has led to overt discrimination, social ostracism, and even deprivations of AIDS victims' civil rights in such areas as employment, housing, and schooling (Mohr, 1987/88). In some instances, persons, who were thought to have AIDS, have been denied entry to shelters. In other cases, fear has led to violence toward AIDS patients living in shelters (Morris, 1988; Kolata, 1988).

Fear of Homosexuality

Fear of homosexuality (homophobia), as a social phenomenon, is both personalized and institutionalized. As with racism and sexism, it has perpetuated oppression of a group that is different from those in the dominant social structure. By definition, homophobia refers to the irrational fear of homosexuality and of the negative attitudes and behavior toward lesbian women and gay men that result (Friedman, 1976). This notion is supported by Gramick (1983) who has added that intolerance of any sexual difference from an established norm may be a symptom of homophobia.

Norton (1987) has contended that homophobia is related to a rigid personality and to a narrow view of sex roles. Further, many men in this country are fearful of homosexuality. Rarely does the literature reference women's fear or lack of fear of female homosexuality. However, recent studies (Blumenfield et al, 1987; Wisniewski and Toomey, 1987) have noted homophobia among women.

Society's response to plagues, epidemics and other disasters is usually a panicked response largely caused by ignorance (Selby, 1984). The Surgeon General

of the U. S. Public Health Service mailed a report to inform the public about AIDS, how it is transmitted, the relative risks of infection and how to prevent it. The purpose was to help the public understand their fears. Research has shown that unreasonable fear can be as crippling as the disease itself. Young (1986) also emphasized, in his study on AIDS, that fear is at the root of prejudice and discrimination against those who have or are at risk for AIDS.

Moral Judgment

Negative moral attitudes toward AIDS patients among health professionals, caregivers and the general public is frequently noted in the literature (Dunkel, and Hatfield, 1986; Kelly, 1987). The following theories on moral development are representative and universally acknowledged as valuable viewpoints that shed light on the complex subject of moral judgment.

Piaget is generally viewed as a giant in modern developmental theory, especially in the area of cognitive development (Duska and Wheeler, 1975). His observations and conclusions have contributed much to understanding the manner in which children progress in various stages of mental/moral reasoning ability

(Schuster and Ashburn, 1980). Another giant in the field of moral development is Kohlberg.

There are close similarities between the theories of Piaget and Kohlberg. Both theorists have shared the assumption that there are a fixed number and order of potential stages in the development of moral reasoning. Both theorists have also used the same basic technique in all their research inquiries. This technique involves the eliciting verbalized rationale for the judgment of specific acts in hypothetical situations (Schuster and Ashburn, 1980).

Kohlberg (1964) is concerned with the principle of justice as compared to Piaget's concern for simple virtues and vices. Gilligan (1982) has extended the theories of Kohlberg and Piaget, which have assumed a single form of moral development. She assumed, for example, that there are male and female forms that are concerned, respectively, with absolute notions of justice and with responsibility and care.

Following a Piagetian orientation, Kohlberg (1964) developed six stages of moral development, ranging from a premoral level through a morality of conventional conformity, to the formulation of self-accepted moral

principles derived by individual reasoning. He has offered a cognitive model of moral development, based on the premise that individuals prefer the highest stage they can comprehend.

Kohlberg's study (1981) has yielded the following six developmental stages which are based on ways of thinking about moral matters. These stages are allotted to three moral levels: 1) the preconventional level, 2) the conventional level, and 3) the postconventional, autonomous, or principled level.

The preconventional level involves Stage One and Stage Two which are characteristic of young children and the focus is on obeying rules. In Stage One, rules are obeyed to avoid punishment. During Stage Two, a person conforms to rules out of self-interest or in relation to what others can do in return. Neither of these stages have much relevance for this study and therefore will not be discussed further. Stages Five and Six, within the postconventional level, will also be omitted. According to Kohlberg (1964), not more than 20 to 25 percent of the adult population have reached either stage.

Stages Three and Four are within the conventional level of morality. In Stage Three, a good boy orientation is designed to win approval and maintain expectations of one's immediate group. Here the child conforms to avoid disapproval and earns approval by being nice.

It is during Stage Four that the individual is concerned with doing his duty. S/he is also intent on showing respect for authority and on maintaining social order. Fear-motivated conditioning at this point can produce rigid but very religious individuals, who are legalistically bound to law and order.

Kohlberg (1981) found women, in light of their strong interpersonal orientation, to favor Stage Three. This is a stage he held to be functional and adequate for them. Gilligan (1982), in her expansion of Kohlberg's work, focused on the traits that have conventionally defined the goodness of women. This goodness involved their care and sensitivity to the needs of others. Gilligan (1982) has also suggested that Kohlberg's scoring system may be biased against women because of the disproportionate number of males in research samples. She has further stated that the

developmental theories themselves tend to be formulated by men.

It would appear that Stages Three and Four have relevance for this study. The fact that most of the homeless shelters are operated by women holds strong implications. Many of the shelters are sponsored by churches and the people, who work in those shelters, usually have strong religious convictions. These religious convictions could result in a biased attitude toward homeless persons with AIDS, especially those who are homosexuals.

Public attitudes toward AIDS are shaped by previously held beliefs toward homosexuals. These beliefs and attitudes have affected both social behavior and public policy. For example, there have been instances in which caregivers have refused to even touch people with AIDS (Mohr, 1987/8).

Review of Related Research

Detailed below are studies which have examined attitudes toward persons with AIDS among medical personnel and the general public along various dimensions. Since most of the studies reviewed examined the knowledge of AIDS in relationship with other variables, the following studies investigated knowledge of AIDS in combination with other factors such as fear and moral judgment.

Fear of AIDS

Existing research has generally focused on fear of contagion and fear of homosexuality as two prominent fears related to AIDS. Fear of AIDS has been operationalized to mean fear of contagion and fear of homosexuality.

Fear of contagion has been defined as being afraid of catching AIDS from working in an area where people with AIDS are thought to reside. Fear of homosexuality (homophobia) was defined as the responses of fear, disgust, anger, discomfort and aversion that individuals may experience in being around homosexuals.

Fear of contagion

Blumenfield, Michael, Smith, Milazzo, Seropian, and Stuart (1987) surveyed 191 nurses concerning their attitudes about caring for AIDS patients. The purpose of this study was to determine if their attitude would differ depending on the type of experience on particular units. In addition, they examined if nurses working in special areas might be better suited for working with AIDS patients.

The 10 question anonymous survey was administered in 1983 and then repeated again in 1984. Two-thirds of the subjects reported that they had friends and/or family members who were concerned about associating with hospital personnel who had contact with AIDS patients.

Between one-forth and one-half of the subjects feared caring for homosexual men and male prisoners because of their awareness of AIDS. Fear of caring for AIDS patients, as compared to caring for patients with hepatitis, was highest among intensive care staff.

Eighty-five percent of the subjects believed that pregnant nurses should not care for AIDS patients. One-half of the subjects indicated they would ask for a

transfer if they had to care for AIDS patients on a regular basis. Treatment and education programs were recommended for hospital staff who worked with AIDS patients.

Using self administered questionnaires, Richardson, Lochner, Thomas, McGuigan, Kimberly and Levine (1987) surveyed 314 heterosexual and homosexual physicians in Los Angeles County. The purpose of the study was to examine their attitudes and experience regarding the care of patients with AIDS. Analysis of covariance (ANCOVA) was used to compare the responses of both groups of physicians. Many of the physicians surveyed indicated that concerns about the risk of contagion with AIDS is a deterrent to treating AIDS patients.

Both heterosexual and homosexual physicians indicated a lack of medical knowledge and experience regarding the opportunistic infections and cancers that are associated with AIDS. Many in both groups expressed a desire to receive more training in this regard. It was suggested that if such training was available, it was likely that sufficient numbers of physicians would be willing to care for AIDS patients.

This need for extensive education for physicians and nurses concerning AIDS has been supported previously in existing literature (Elford, 1986; Durham and Cohen, 1987).

Fear of homosexuality

The need for extensive education for physicians concerning AIDS has also been noted in a study by Kelly, St. Lawrence, Smith, Hood, and Cook (1987) of 119 medical students' attitudes toward AIDS, and homosexual patients. The subjects read one of four patient vignettes that were identical in content except that the patient was identified as having either AIDS or leukemia. The patient was also identified as either homosexual or heterosexual.

Multivariate and univariate analyses of variance of their responses revealed that the students held negative and prejudiced attitudes toward both the AIDS, and homosexual patients. Findings suggested that medical educators should recognize that many students have stigmatizing, negative attitudes toward homosexuals and patients with AIDS. Therefore, greater sensitivity, knowledge, and understanding among medical students of AIDS patients and of those at risk

for AIDS should be promoted to eliminate or reduce negative attitudes toward patients with AIDS.

Results in this study were suspect, however. There was no mention of randomization or pre and post-tests although analyses of variance and multivariate analysis were utilized. These practices violated the requirements of a priori assumptions for these statistical procedures.

However, other studies found similar negative attitudes toward homosexuals. For example, Douglas, Kalman, M., and Kalman P. (1985) conducted a study on homophobia among medical house officers and registered nurses. Thirty-seven physicians (41 percent) and 91 nurses (35 percent) completed returned questionnaires which included the Index of Homophobia scale (IHP), demographic information and eight questions pertaining to homosexuality and AIDS.

It was found that 31% of nurses and interns reported feeling more negative towards homosexuals since the emergence of AIDS. They also found that nine percent of the their sample responded affirmatively to the statement that "Homosexuals who contract AIDS are getting what they deserve."

It was concluded that homophobia is higher than desirable in this group of health professionals. This finding of significant homophobia in such a group of caregivers could have important implications for patient care since moral judgment strongly directs one's behavior (Kohlberg, 1964).

Limitations of the study included the relatively low response rate and the possibility of a responder versus-nonresponder sampling bias. It was difficult from this publication to ascertain whether responses truly reflected actual attitudes as opposed to a respondent's trying to answer correctly. In addition they had no control group in the general population or within the health care community with which to compare the study's sample.

The results of this study indicated that a disturbingly high percentage of the health professionals acknowledged more negative, even overtly hostile feelings toward homosexuals than they had before the emergence of the AIDS epidemic. This supports the findings of Temoshok, Sweet, and Zich (1987). For example, there was significant negative correlation between the level of knowledge about AIDS

and fear of AIDS and anti-homosexual attitudes among the study population.

A study of 77 social workers in Columbus, Ohio was conducted by Wisniewski and Toomey (1987). The study was designed to assess whether social workers evaluated gay and heterosexual males differentially based on information obtained from 20 items from Hudson's Index of Attitudes toward Homosexuals (IAH). A stepwise multiple regression analysis was completed with participant's scores on IAH as the dependent variable. As measured by the IAH, nearly one-third of the participants earned scores falling in the homophobic classifications. Therefore, the scores obtained in this study support the need for increased personal and academic training of social workers in homosexual issues.

The methods used in this study seemed to be somewhat flawed. The authors used different kinds of research methods. For example, 102 packets were mailed to social workers with MSWs and 25 packets mailed to those listed in the social work register in Columbus, Ohio. There was no apparent control over the distribution of packets. Nevertheless, the results of this

study lend preliminary empirical support to the implied assumption that social workers manifest signs of homophobia. In addition, prior research (Gramich, 1983) has also found that social workers who manifested signs of homophobia were presumed to be less effective, if not harmful, in the delivery of services.

Moral Judgment

Moral judgment was defined as preconceived beliefs or attitudes about people with AIDS. A negative attitude would be the belief that the person with AIDS deserves the disease. Social reactions to AIDS are a mixture of uniformed prejudice, fear, loathing, righteous indignation and a wish to isolate the victims. Perhaps the worst aspect is the attitude of some health workers which reinforces the stigma (Bennett, 1987). Several studies have validated stigmatized attitudes toward persons with AIDS. For example, Bohne (1986) surveyed 29 hospital chaplains in New York City regarding the amount of experience and the types of visits they made to people with AIDS. Six chaplains were interviewed, and informal interviews were conducted with people who had AIDS.

Sixteen of 23 chaplains who answered a question concerning the pastoral needs of persons with AIDS indicated that these patients reported the same issues as any patient with a life-threatening illness. Sixty-nine percent of the chaplains indicated that they experienced no fear of contagion when visiting AIDS patients.

By contrast, 14% of the chaplains condemned the homosexual AIDS patient's sexuality. It was suggested that reinforcing a homosexual's self-hatred was of no spiritual or psychological value and may cause a primitive splitting of the patient's self from his sexuality.

Katz, Hass, Parisi, Astone, McEvaddy, and Lucido (1987) examined lay people's and health care personnel's perceptions of cancer, AIDS, cardiac and diabetic patients. The mixed sample included 433 college students, nurses, medical students, and chiropractic students. The subjects rated cancer, AIDS, diabetes, and heart disease patients as well as the non-ill on a 21 bipolar trait-adjective scale.

Scale items measured competence, moral worth, dependence, depression, morbidity, social distance,

cancer anxiety, disease beliefs, and ascribed illness responsibility. Overall, subjects perceived cancer victims less favorably than diabetics, heart patients, and the non-ill on competence, dependence, depression, and morbidity. People with AIDS were generally the most negatively evaluated and the most rejected group.

There were no explanations given for several actions taken in this study. First, there was no explanation for why such a mixed sample was chosen. Second, no indication of the level of education among the 158 lay people was offered. This would appear to be important since the educational levels were mentioned regarding the other two groups of subjects. Finally, there was no explanation as to why only college students were given the Cancer scale. As a result, this study could only be generalized to those subjects.

The finding that AIDS patients were the most rejected group is consistent with findings from Triplet and Sugarman (1987). This study tested the hypotheses that negative reactions toward victims of AIDS reflected fear of the unknown or victim derogation.

Fifty-eight undergraduates rated the personal responsibility and interactional desirability of eight hypothetical disease victims who varied on their sexual preference and on their diagnosis. Thirty of the subjects were recruited from four psychology courses at a small private New England college and the remaining 28 from the introductory psychology subject pool at a medium-sized New England state university. A four-group one-way ANOVA was performed on the seriousness measure in order to check the diagnosis manipulation.

Results showed that while the homosexual victims were rated more personally responsible for their disease, AIDS victims were rated the least interactionally desirable. It was suggested that the reaction against AIDS victims reflected a fear of the unknown causes of the disease, coupled with a general prejudice against homosexuals.

Subjects were from differing educational levels in a private New England college. For example, some were freshmen, some were sophomores, and others were juniors and seniors. Yet, this study offered no description of subjects' level of education. Consequently, different results might have been produced if

the experiences of subjects in various educational levels had been examined. However, this study supported other studies that have suggested that the reaction against AIDS victims reflects a fear of the unknown causes of the disease, coupled with a general prejudice against homosexuals (Katz et al., 1987; Royse and Birge, 1987).

AIDS training has been recommended in the majority of the above studies (Blumenfield, et al., 1987; Richardson, et al., 1987; DiClemente, Zorn, and Temoshok, 1987). The studies listed below are directly concerned with examinations of the effects of AIDS training on study subjects.

O'Donnell, O'Donnell, Pleck, Snarey, and Rose, 1987) examined the effects of in-service education on knowledge and perceived risks and stresses of 237 hospital workers. Personal interviews were administered to 150 employees. An additional 87 staff members returned self-administered questionnaires.

The purpose of the study was to determine the perceptions of the risks and stresses of AIDS patient care among hospital workers. Results revealed that for a substantial minority (23.9%) of individuals,

job-related exposure to AIDS patients was perceived as a personal health threat. This fear was explained by an inaccurate understanding of how AIDS was transmitted. For example, those in job categories most likely to overestimate the possibility of contracting AIDS through casual contact also felt at greatest risk of contracting the disease.

AIDS-Phobia, including fears of contagion, was positively correlated with Homophobia and AIDS-Stress. It was suggested that AIDS-Phobia, and ultimately AIDS-Stress were heightened by negative attitudes about homosexuality. Overall findings revealed that while probably more knowledgeable than the general public about health issues, hospital workers were not immune to AIDS fears. However, close contact with AIDS patients allowed them to come to terms with their fears. This survey suggested that most workers would benefit from special education and support in that process.

One group of hospital workers completed a self-administered questionnaire; an interview format was used with the other group. Although it was stated that both groups were comparable, there was no mention of

any test to show they were comparable in the knowledge area.

In a study of 212 college-age young adults in Kansas City, Simkins and Kishner (1986) examined attitudes toward AIDS, Herpes II, and Toxic Shock Syndrome (TSS). The purpose of this investigation was to determine if there had now been any corresponding changes in attitudes toward those diseases. In addition they wanted to determine if any of these diseases had affected sexual activity. Further, the relationship between homophobia and the extent of concern about the diseases were examined. Results showed that the majority of the respondents expressed little concern about any of these diseases.

As in a previous study (Simkins and Eberhage, 1984), men expressed more concern about contracting AIDS from their present sexual partners than did women. However, unlike the Simkins and Eberhage (1984) study, it was found that neither males nor females were concerned about contracting AIDS from future partners. Results suggested little change either in homophobic attitudes or sexual behavior for most subjects.

The study also found a low but significant correlation between homophobic attitudes and concern about AIDS and herpes. This may have reflected the comparative prevalence of the two conditions in college-age populations rather than erroneous risk perceptions about either AIDS or herpes. The results of this study are consistent to some extent with those reported by Gabay and Morrison (1985) who found no differences in AIDS-phobia between 1984 and 1985.

In general, the work of Simkins and Kushner (1986) yielded no differences in the attitudes or in amount of sexual activity concerning AIDS or Herpes II from those observed in the 1984 investigation. Men, particularly homosexuals, continued to be the most concerned about AIDS. Even the level of concern registered by this group was not different from that noted in Simkins and Eberhage (1984).

However, the sample of male homosexuals was very small (10%). Therefore, these results may not have been representative of the gay male community in the metropolitan area of Kansas City. Despite the fact that there have been a few cases of sexually transmitted AIDS among the heterosexual population, a

number of heterosexuals in this sample still viewed AIDS as basically a "gay disease."

Wertz, Sorenson, Liebling, Kessler, and Heeren (1987) examined knowledge and attitudes of AIDS health care providers before and after education programs. Analysis of the responses of 1,247 health care providers to pre and posttest questionnaires, with respect to AIDS-related educational programs, revealed significant improvements in accuracy of knowledge about modes of transmission and seven of eleven means of infection control. Unspecified percentages continued to believe after the programs that AIDS could be transmitted by casual contact, such as sharing coffee cups.

After being exposed to the educational programs, 92 percent of the providers believed that they had sufficient knowledge to protect themselves from getting AIDS, while 79 percent felt professionally competent to care for a person with AIDS. Both before and after program providers who established regulations for the care of persons with AIDS and outpatient care providers had the most accurate knowledge and felt most comfortable with persons who had AIDS.

Meanwhile, inpatient care providers had the least accurate knowledge and felt least comfortable. A one-month follow-up of 159 providers revealed that post program changes in knowledge and attitudes were largely retained after the educational modality had been administered.

Summary

The review of related studies has suggested that attitudes toward persons with AIDS may occur along various dimensions. The most common dimensions appeared to be knowledge, fear and moral judgments.

It seems evident from the literature and studies reviewed that fear of contagion and fear of homosexuals are attitudes prevalent in the majority of subjects tested. Consequently, fear of contagion appears to be a prevailing attitude because people continue to fear for their physical safety and that of their families.

Although other groups are known to be at risk for AIDS, homosexuals are still thought of as the primary carriers of the disease. Therefore, a considerable amount of prejudice appears to exist toward them. As a consequence, people may continue to hold negative

moral judgments toward persons with AIDS. The majority of the studies reviewed recommended AIDS education as a method to eliminate such negative attitudes and also as a means of providing knowledge regarding protective measures.

Need for the Study

On a national level, there has been an increase in the number of homeless people who have sought shelter services. Simultaneously, there has been an increase in homeless people with AIDS seeking shelter services. The review of literature and related studies has failed to show that AIDS research has been conducted which examined the effect of intervention modalities on shelter directors to affect attitudinal change.

In addition, an abundance of ignorance appears to exist regarding precautionary measures that should be taken by shelter staff for their own protection against this disease. However, there is no evidence that research has been conducted in this area. It would seem, therefore, that education and training, which combines precautionary measures and attitudinal change, should be provided to shelter directors regarding knowledge, fear and moral judgment.

Purpose of the Study

The purpose of this study was to examine the attitudes of shelter directors toward AIDS through an educational modality. More specifically, this modality was used to determine the impact of AIDS education and training on three attitudinal levels: (1) knowledge about AIDS, (2) fear of AIDS, and (3) moral judgment toward people with AIDS.

Study Hypotheses

There were three study hypotheses. They are listed below:

Hypothesis #1

There will be a change in the knowledge pre and posttest scores indicating an increase in knowledge about AIDS by study subjects.

Hypothesis #2

There will be a change in the fear pre and posttest scores indicating a decrease in fear of AIDS by study subjects.

Hypothesis #3

There will be a change in the moral judgment pre and posttest scores indicating a decrease in negative moral judgments toward persons with AIDS by study subjects.

CHAPTER II

Methodology

Site and Setting

The setting for this study was Atlanta, Georgia. Atlanta is a large metropolitan city in which there are approximately 55 homeless shelters. Each month in Atlanta, shelter directors and service providers meet at a chosen shelter location to discuss issues relevant to those who work in emergency shelters for the homeless. One of the more recent concerns among this group was the subject of AIDS. The Atlanta Task Force for The Homeless is the coordinating body for all meeting agenda. In cooperation with the Task Force, an agreement was made to choose the topic of "AIDS in the Shelters" for the January meeting and allow study data to be collected during the meeting.

The site chosen for this study was a Jewish community center located in northeast Atlanta. It sponsors an on-site shelter for 12 single women. The January meeting was held there and this research study was conducted at that time. Monthly meetings normally last two hours and includes a free meal.

Subject Pool

The present study involved approximately 60 shelter directors and service providers in Atlanta, Georgia, representing fifty shelters, who attended the monthly meeting held on January 19, 1989. All subjects were notified, as to the purpose of the study (see Appendix F). Since the entire population of shelter directors and service providers were asked to participate in this study, there was no need for random selection.

Sample

The sample consisted of 40 members of the subject pool who a) attended this January meeting, and b) completed the pre and posttests.

Design

The design for this study was a quasi-experimental/associational or one-group pretest/posttest. The strategy of associational designs is to determine if there is significant difference between the dependent variable at pretest as compared to posttest. This design is particularly useful for the generating of associational knowledge, as a first approximation to cause-effect knowledge (Tripodi, 1985).

The study contained three independent variables: (1) knowledge, (2) fear, and (3) moral judgment; three dependent variables: (1) scores of knowledge, (2) scores of fear, and (3) scores of moral judgment as measured by the survey instrument.

Knowledge

Knowledge about AIDS was defined as knowledge about the causes of AIDS, modes of transmission and prevention, and groups at risk for getting AIDS.

Fear

Fear of contagion was defined as being afraid of catching AIDS from working in an area where people with AIDS are thought to reside. Fear of homosexuals (homophobia) was defined as the responses of fear, disgust, anger, discomfort and aversion that individuals may experience in being around homosexuals.

Moral Judgment

Moral judgment was defined as preconceived beliefs or attitudes about people with AIDS. A negative attitude would be the belief that the person with AIDS deserves the disease.

Educational Modality

The purpose of the education manipulation was to provide information about AIDS to shelter directors in order for them to disseminate this knowledge to shelter staff and volunteers. Three presenters, speaking for fifteen minutes each, were responsible for the education manipulation:

1) The associate director of education from AID Atlanta addressed issues in the knowledge segment.

2) An AIDS coordinator and biologist from Centers for Disease Control addressed issues related to fear of AIDS.

3) A minister and co-director from the Atlanta Task Force for the Homeless addressed the subject of moral judgment.

A question and answer period followed the presentations. The educational period lasted approximately one hour.

Instrument

A number of sources of information were used in developing the questionnaire. These included the literature, personal knowledge and experience of the researcher, and extensive interviewing of shelter directors and shelter providers. The interviews enabled the researcher to identify their attitudes and

feelings about working in emergency shelters where persons with AIDS are thought to reside. Once the instrument was completed, it was revised to address the concerns of shelter staff members and shelter providers. It was then pretested on seven shelter providers who work in some capacity with emergency shelters. Questions that needed rewording were then identified and other necessary changes were made.

Instrument Description

The Shelter Directors and Service Providers Survey consisted of two sections: Section A contained demographics, while Section B contained perceptions and opinions of shelter respondents.

Section A - Demographics

This section contained 19 items for the purpose of collecting vital statistics on the study population, i.e., age, sex, and race. It also contained shelter related information.

Section B - Perceptions and Opinions

This section contained 36 questions related to perceptions and opinions of the study population for the purpose of collecting data about the sample population for testing the study hypotheses. They are detailed below:

1) 10 items on knowledge to test the knowledge of respondents of current facts related to AIDS.

2) 10 items on fear of AIDS: questions devised to ascertain the degree of fear shelter directors and staff experience concerning being around people with AIDS, and homophobia.

3) 15 items on moral judgment: questions devised to determine whether shelter directors and staff held negative moral judgment toward persons with AIDS.

Three types of response scales were utilized: 1) multiple-choice, 2) one open-ended question in the posttest to be used for the purpose of obtaining insight that no amount of statistical data would reveal, and (3) a summated, four response Likert-type scale was used for questions in Section B (e.g., 1-Strongly Disagree, 2-Disagree, 3-Agree, 4-Strongly Agree).

Procedures

There were seven procedures in this study. They are listed below:

Month I: Procedure 1. A letter of agreement was sent to the Atlanta Task Force for the Homeless. This was a contract for use of study site space (see Appendix A).

Procedure 2. A letter of agreement was sent to the presenter at the Centers for Disease Control (CDC). This was a contract to provide AIDS training and education related to the variables under study and also to protect the researcher's study (see Appendix B).

Table 2.1 Research Procedures for Months 1, 2, and 3; Administration and Instrument Utilization

ACTIVITY PERIOD	PROCEDURE	ADMINISTRATION	INSTRUMENT UTILIZATION
MONTH 1	Procedure 1 Mailed letter of agreement	Sent to Atlanta Task Force for the Homeless	Letter of agreement (Appendix A)
	Procedure 2 Mailed letter of agreement	Sent to Centers for Disease Control (CDC)	Presentation Contract (Appendix B)
	Procedure 3 Mailed letter of agreement	Sent to AID Atlanta	Presentation Contract (Appendix C)
MONTH 2	Procedure 4 Pre-tested instrument	Utilized shelter service providers for pilot testing	Shelter Directors and Service Providers Survey (Appendices D and E)
	Procedure 5 Mailed letter	Sent to shelter directors and service providers	Letter of Notification (Appendix F)
MONTH 3	Procedure 6 Conducted Study	a. Self administered to/by sample population at study site b. Question and answer period	Self/administration of pre and posttest to sample (Appendices D and E)
	Procedure 7	Research activity terminated	

Procedure 3. A letter of agreement was sent to the presenter from AID Atlanta. This was a contract to provide AIDS training and education related to variables under study and also to protect the researchers study (see Appendix C).

Month II: Procedure 4. The Shelter Directors and Service Providers Survey was pre-tested, using several shelter service providers who were unable to attend the meeting. Modifications were then made as deemed necessary (See Appendixes D/E).

Procedure 5. A letter was mailed 10 days prior to the January meeting to shelter directors and service providers representing all shelters for the homeless in Atlanta. In this letter, the purpose of the study was explained and their participation was requested (see Appendix F).

Month III: Procedure 6. Between 12 noon and 12:15 P.M. on the meeting date, when shelter directors and service providers, who are the subjects for the study entered the site, they were given two coded envelopes. One envelope contained a pretest, while the other envelope contained a posttest (see Appendixes D/E). Subjects were then given a brief introduction as to the

purpose of the study. They were instructed that the test is self-administered and would take approximately 5 minutes to complete.

They were then asked to open Envelope #1 and to respond to each question by circling the appropriate answer. The intervention began at 12:30 and took place for approximately one hour. Each presenter addressed a specific issue (i.e., lack of knowledge, fear of AIDS and moral judgment toward persons with AIDS). After the intervention, all subjects were asked to complete the posttest. When the questionnaires were completed and collected, participants then asked questions of the presenters. When questioning was completed, they exited the setting and resumed normal activities.

Procedure 7. The research was terminated.

Data Collection

Data was collected on three dimensions: 1) knowledge, 2) fear and 3) moral judgment. All data was collected by the researcher.

Data Analysis

Analyses of all data were performed at the Atlanta University Computer Center on the UNIX 3-B15 System utilizing the Statistical Package for the Social Sciences (SPSS). The specific analytical procedure included: measures of central tendency, frequency and percentage distributions, and t-tests.

CHAPTER III

Results

Results from this study are confined to two sections: Section A and Section B. Section A includes results regarding demographic data and shelter related information. Meanwhile, Section B includes results regarding perceptions and opinions.

Section A 1: Demographic Data

Table 3.1 Sample Demographic Characteristics by Age, Sex, Race and Religion in Numbers (#s) and Percents (%s) (N=40)

Age	#	%
21 - 25	2	5
26 - 30	2	5
31 - 35	6	15
36 - 40	3	7.5
41 - 45	9	22.5
46 - 50	8	20
51 & above	10	25
Total	40	100.0

Sex	#	%
Female	27	67.5
Male	13	32.5
Total	40	100.0

Race	#	%
Black	16	40
White	15	37.5
No Response	9	22.5
Total	40	100.0

Religion	#	%
Catholic	1	2.5
Protestant	26	65
Jewish	3	7.5
Non-denomination	3	7.5
Other	5	12.5
None	2	5
Total	40	100.0

Demographic data included the following variables: age, sex, race, religion, marital status, education, income, and number of children. Results are presented above, and below, as calculated by frequency analysis.

Age

As shown in Table 3.1, of 40 survey respondents, two (or 5%) were between 21-30 years of age; six (or 15%) were between 31-35; meanwhile three (or 7.5%) were between 36-40; eight (or 20%) were between 41-50 and 10 (or 25%) were between 46-50 years of age. Therefore, the typical survey respondent was 51 years of age or older.

Sex

As shown in Table 3.1, of 40 survey respondents, 27 (or 67.5%) were female and 13 (or 32.5%) were male. Therefore, the typical survey respondent was female.

Race

As shown in Table 3.1, of survey respondents, 16 (or 40%) were Black, 15 (or 37.5%) were white and nine (or 22.5%) gave no response. Therefore, the typical survey respondent was Black.

Religion

As shown in Table 3.1, of 40 survey respondents, one (or 2.5%) was of the Catholic religion; 26 (or 65%) were Protestant; three (or 7.5%) were Jewish and non-denominational, respectively; five (or 12.5%) were other and two (or 5%) gave no response. Therefore, the typical respondent was of the Protestant religion.

Table 3.2 Results of frequency of analysis by Marital Status, Education, Income and Number of Children (N = 40)

Marital status	#	%
Single	8	20
Married	18	45
Cohabitant	2	5
Divorced	7	17.5
Widowed	2	5
Separated	1	2.5
No response	2	5
Total	40	100.0

Education	#	%
High School	5	12.5
College	22	55
Masters	8	20
Post Graduate	3	7.5
No response	2	5
Total	40	100.0

Income	#	%
$ 4,999 and under	4	10
5,000 - 9,999	1	2.5
10,000 - 19,999	10	25
20,000 - 29,000	10	25
30,000 - 39,000	0	25
40,000 - 49,000	2	5
50,000 and over	2	5
No response	1	2.5
Total	40	100.0

Children	#	%
None	15	37.5
One	7	17.5
Two	8	20
Three	6	15
Four	1	2.5
Five or more	3	7.5
Total	40	100.0

Marital Status

As shown in Table 3.2, of the 40 survey respondents, eight (or 20%) were single while 18 (or 45%) were married. In addition, two (or 5%) survey respondents were cohabitants, seven (or 17.5%) were divorced, two (or 5%) were widowed and one (or 2.5%) were separated. Two (or 5%) did not respond to this item. Therefore, the typical survey respondent was married.

Education

As shown in Table 3.2, of the 40 survey respondents, five (or 12.5%) had completed high school; 22 (or 55%) had completed college; 8 (or 20%) had completed a masters program; three (or 7.5%) had completed post graduate work and two (or 5%) did not respond to this item. Therefore, the typical survey respondent was college educated.

Income

As shown in Table 3.2, of the 40 survey respondents, ten (or 25%) had incomes ranging from $10,00 to $39,000; four (or 10%) had incomes in the $4,999 and under category; one (or 2.5%) had incomes ranging from $5,000 to 9,000; two (or 5%) had incomes

in both the 40,000-49,000 and in the 50,000 and over category. One (or 2.5%) did not respond to this item. Therefore, the typical survey respondent had incomes ranging from $20,000 to $39,000.

Number of Children

As shown in Table 3.2, of the 40 survey respondents, fifteen (or 37.5%) had no children; seven (or 17.5%) had one child; eight (or 20%) had two children; six (or 15%) had three children; one (or 2.5%) had four children and three (or 7.5%) had five or more children. Therefore, the typical respondent had no children.

Summary

The typical survey respondent was a 51 year old Black Protestant married female who had completed college at the undergraduate level. She had no children and had an annual income range of $10,000 to $39,000.

Section A 2: Shelter Related Information

Months/Years of Affiliation

As shown in Table 3.3, of the 40 survey respondents, nine (or 22.5%) had been affiliated with the homeless from zero to two years; five (or 12.5%) for three to four years; and 17 (or 42.5%) had been affiliated between four to five years. Therefore, the typical time period of affiliation with the homeless was one to two years.

Table 3.3 Results of Frequency of Analysis by Number of Months/years Affiliated with Homeless, Current Position and Length of Time in Position (N = 40)

Months/years	#	%
0 - 6 months	9	22.5
1 - 2 years	9	22.5
3 - 4 years	5	12.5
4 - 5 years	17	42.5
Total	40	100.0

Current Position	#	%
Administrative	15	35.5
Service Providers	10	25
Other	5	12.5
Paid Staff	4	10
Volunteers	3	7.5
No response	3	7.5
Total	40	100.0

Length of Time in Position	#	%
0 - 6 months	12	30
1 - 2 years	13	32.5
3 - 4 years	5	12.5
5 years or more	7	17.5
No response	3	7.5
Total	40	100.0

Current Position

As shown in Table 3.3, of the 40 survey respondents, fifteen (or 37.5%) held administrative positions; ten (or 25%) were service providers; five (or 12.5%) held other positions; four (or 7.5%) were paid staff while three (or 7.5%) were either volunteers or did not respond to this item. Therefore, an administrative position was the typical position held by a survey respondent.

Length of Time in Position

As shown in Table 3.3, of the 40 survey respondents, 12 (or 30%) had held their position up to six months; 13 (or 32%) had held their position for one to two years. Five (or 12.5%) had held positions for three to four years and seven (or 17.5%) had held positions for five years or more. Finally, three (or 7.5%) did not respond to this item. Therefore, the typical survey had held their position for one to two years.

Shelter Descriptors

As shown in Table 3.4, shelter descriptors were rank ordered relative to the respondents' choices. The typical shelter in which the 40 survey respondents

were affiliated was private and non-profit. The typical shelter was a year-round, 24 hour facility which housed men, women and children.

Table 3.4 Shelter Descriptors: Funding type, operational periods, client population and shelter services

Funding Types	#
Non-profit	25
Private	15
Public	10

Operational Period	#
Day	10
Night	17
24 hour	18
Year round	22
Winter only	11
Transitional	9

Client Population	#
Men	16
Women	18
Children	12
Families	12
Husbands/wives	9
Women and children	13
Men/women/children	12

As shown in Table 3.5, of the 40 survey respondents, seven (or 17.5%) were associated with shelters that accommodated 30 persons. Other respondents worked in shelters with a capacity range

from 12 to 250 persons. The majority 18 (or 45%) did not respond to this item.

Table 3.5 Shelter Capacity in Numbers (#s) and Percents (%s)

	#	%
250	1	2.5
200	1	2.5
110	1	2.5
65	2	5
55	1	2.5
50	1	2.5
45	1	2.5
40	4	10
30	7	17.5
24	1	2.5
12	2	5
No response	18	45
Total	40	100.0

Table 3.6 Shelter Services by Rank Order

1.	meals	27
2.	showers	27
3.	counseling	25
4.	supportive services	24
5.	telephone	22
6.	laundry	21
7.	mentally ill agency referrals	21
8.	health screening	18
9.	physical health services	18
10.	child care	15
11.	sick rooms	10
12.	legal services	9

As shown in Table 3.6, the top five shelter services were meals, showers, counseling, supportive

services and telephone accessibility as determined by rank ordering.

Table 3.7 Health Conditions by Rank Order

1.	Upper respiratory infections	17
2.	None of those listed	10
3.	AIDS	9
4.	Tuberculosis	8
5.	Malnutrition	8

As shown in Table 3.7, the typical health condition found in shelters operated by respondents was upper respiratory infections as determined by rank ordering.

Summary

The typical survey respondent had been affiliated with the homeless four to five years and had held an administrative position for one to two years. The typical shelter was a non-profit, private, year round 24 hour facility which housed men, women and children. In addition, the typical shelter capacity was 30 and the typical shelter provided services such as meals and showers. Finally, the typical health condition found in shelters operated by respondents was upper respiratory infections.

AIDS-related Information

Below are results of questions asked to determine survey respondents' awareness of AIDS "at risk" behaviors in the shelters and to ascertain if respondents had received AIDS training prior to the study intervention.

Item #15: To your knowledge, has a person with AIDS ever stayed in the shelter you work in? Of the 40 survey respondents, 13 (or 32.5%) answered Yes; 18 (or 45%) answered No and nine (or 22.5%) did not respond to this item.

Item #16: To your knowledge, do shelter residents in the shelter you work in share needles? Of 40 survey respondents, five (or 12.5%) answered Yes; 25 (or 62.5%) answered No and 10 (or 25%) did not respond to this item.

Item #17: To your knowledge, do shelter residents in the shelter you work in engage in sexual activities on site? Of the 40 survey respondents, six (or 15%) answered Yes; 26 (or 65%) answered No and eight (or 20%) did not answer this item.

Item #18: Have you ever had any kind of AIDS training prior to today? Of 40 survey respondents, 22

(or 55%) answered Yes; 11 (or 27.5%) answered No and seven (or 17.5%) did not answer this item.

Item #19: Has AIDS training ever been conducted in your shelter? Of 40 survey respondents, six (or 15%) answered Yes; 26 (or 65%) answered No and eight (or 20%) did not answer this item.

Summary

The typical response to the awareness of needle sharing and/or sexual activities in shelters was No. The typical respondent had AIDS training prior to the study; however, no AIDS training had ever been conducted in most of the shelters.

Section B: Attitudes by Three Dimensions: Knowledge, Fear and Moral Judgment

This section contained perceptions and opinions of the shelter directors and service providers. There were 10 knowledge items, 10 fear items and 15 moral judgment items (see also Appendix G for responses by dimensions).

Knowledge Dimension and Hypothesis One

The knowledge dimension was related to Hypothesis One. This hypothesis stated that there would be a change among survey respondents in the knowledge pre and posttest scores. Changes in scores would be indicative of an increase in knowledge about AIDS.

The knowledge dimension consisted of ten items. They were Items #3, 5, 10, 12, 15, 24, 28, 29, 31, 34 (see also Appendix G).

Item 3: The best protection against the spread of the AIDS virus is proper education.

Item 5: The AIDS virus can be killed by a 10% bleach solution.

Item 10: A person who has the AIDS virus is worse off than a person who is known to have AIDS.

Item 12: There is now a test for AIDS.

Item 15: Only people who are homosexual/bisexual, IV drug users, prostitutes, and hemophiliacs can be infected with the AIDS virus.

Item 24: AIDS is a disease caused by a virus that can damage the brain.

Item 28: Not sharing needles is one recommended AIDS prevention measure for IV drug users.

Item 29: AIDS is a disease caused by a virus that can weaken the immune system.

Item 31: A person can be infected with the AIDS virus but never actually get AIDS itself.

Item 34: You can't tell by looking that someone has AIDS.

Table 3.8 Knowledge Dimension Pre/Posttest

	Pretest (N = 40)	Posttest (N = 40)
Mean	21.850	23.256
Standard Deviation	3.807	3.878
Variance	14.493	15.038
t = -1.63	df = 78	p = .108

As shown in Table 3.8, the mean scores for the knowledge dimension were 21.850 and 23.256 for

pre and posttests respectively. The corresponding standard deviations and variances were 3.807 (14.493) and 3.878 (15.038). Results showed that the t-value was 1.63 (df = 78, p = >.05). These scores were not significant at the .05 level. Therefore, Hypothesis One was not supported by the data.

Fear Dimension and Hypothesis Two

The fear dimension was related to Hypothesis Two. This hypothesis stated that there would be a change among survey respondents in the fear pre and posttest scores. Changes in scores would be indicative of a decrease in fear of AIDS.

The fear dimension consisted of ten items. They were Items #1, 2, 9, 17, 18, 21, 25, 30, 32, 33 (see also Appendix G).

Item 1: People who provide help for someone with AIDS are not personally at risk for getting AIDS.

Item 2: I am not afraid of getting AIDS from casual contact, like shaking hands.

Item 9: Although I work in a homeless shelter, I am not at risk for contracting AIDS or the AIDS virus.

Item 17: The thought of being around someone who has AIDS does not bother me.

Item 18: I would allow my children to play with children who have AIDS.

Item 21: I would quit my job before I would work with someone who has AIDS or the AIDS virus.

Item 25: If I learned that someone in the shelter I work in has AIDS, I would be afraid to be around that person.

Item 30: I would be afraid to eat in a restaurant where waiters were homosexuals.

Item 32: I am more afraid to be around drug users than homosexuals.

Item 33: I am not afraid of getting AIDS from causal contact, like hugging.

As shown in Table 3.9, the mean scores for the fear dimension were 23.800 and 24.615 respectively. The corresponding standard deviations and variances were 4.059 (16.475) and 3.361 (11.296). Results showed that the t-value was -.97 (df=78, p=>.05). These scores were not significant at the .05 level. Therefore, Hypothesis Two was not supported by the data.

Table 3.9 Fear Dimension Pre/Posttest

	Pretest (N = 40)	Posttest (N = 40)
Mean	23.800	24.615
Standard Deviation	4.059	3.361
Variance	16.475	11.296
t = -.97	df = 78	p = .334

Moral Judgment Dimension and Hypothesis Three

The moral judgment dimension was related to Hypothesis Three. This hypothesis stated that there would be a change among survey respondents in the moral judgment pre and posttest scores. Changes in scores would be indicative of a decrease in negative moral judgments toward people with AIDS.

The moral judgment dimension consisted of 15 items. They were Items #4, 6, 7, 8, 11, 13, 14, 16, 19, 20, 22, 23, 26, 27, 35 (see also Appendix G).

Item 4: Children with AIDS should be isolated from other children in the shelters.

Item 6: People should voluntarily go to sanitariums to protect others from AIDS.

Item 7: Limiting the spread of AIDS is more important than trying to protect the rights of people with AIDS.

Item 8: Homeless people with AIDS should be allowed to stay in shelters with other homeless people.

Item 11: I think homosexuals with AIDS get what they deserve.

Item 13: There should be voluntary AIDS testing in homeless shelters for staff volunteers.

Item 14: People with AIDS should not be allowed to handle food in restaurants.

Item 16: There should be mandatory AIDS testing in homeless shelters for residents.

Item 19: The spread of AIDS in the United States is proof that homosexual behavior should be illegal.

Item 20: The spread of AIDS in this country is proof that homosexuality should be illegal.

Item 22: There should be voluntary drug testing for shelter residents.

Item 23: Insurance companies should not be allowed to cancel insurance policies for AIDS-related reasons.

Item 26: Separate shelters should be available for homeless with AIDS.

Item 27: I do not think AIDS is a punishment for immoral behavior.

Item 35: I think IV drug users with AIDS get what they deserve.

Table 3.10 Moral Judgment Pre/Posttest

	Pretest (N = 40)	Posttest (N = 40)
Mean	29.025	30.000
Standard Deviation	4.264	3.907
Variance	18.180	15.264
t = -1.06	df = 78	p = .293

As shown in Table 3.10, the mean scores for the moral judgment dimension were 29.0250 and 30.0000 respectively. The corresponding standard deviations (and variances) were 4.264 (18.180) and 3.907 (15.264). Results showed that the t-value was -1.06 (df = 78, p = >.05). These scores were not significant at the .05

level. Therefore, Hypothesis Three was not supported by the data.

Summary

A mild difference was found between pre and posttest scores of knowledge, fear and moral judgment. Difference between mean scores ranged from .815 to 1.406. However, none of these observed differences were found to be statistically significant, when a t-test was conducted on these scores. Consequently, Hypotheses One, Two and Three were rejected.

No statistical support was gained at the .05 significance level to prove differences between the pre and posttest scores on the following three dimensions: knowledge, fear and moral judgment. Consequently, there was a strong relationship between the pre and posttest scores to such an extent that 9,999 times out 1,000 one would be correct in saying that there was no change.

CHAPTER IV

Discussion

The purpose of this study was to examine the attitudes of shelter directors and service providers toward AIDS through an educational modality. This modality was used to determine the impact of AIDS education and training on three levels. They were (1) knowledge, (2) fear of AIDS which included fear of contagion and fear of homosexuality, and (3) moral judgment against people who have AIDS. Results of the study are discussed below.

Knowledge Dimension

Knowledge was defined as knowledge about the causes of AIDS, modes of transmission and prevention, and groups at risk for getting AIDS. It was stated in Hypothesis One that there would be a change in the knowledge pre and posttest scores of shelter directors and service providers indicating an increase in knowledge about AIDS. This hypothesis was not given support by the data. Results had shown that when the means of the pretest were compared to the posttest, there was

little difference between the scores. However, the results from the pre and posttest revealed that respondents were more homogeneous on the posttest than on the pretest.

An investigation of a study by Wertz et al., (1987) examined knowledge and attitudes of AIDS health care providers utilizing before and after education programs. That study revealed significant improvements in accuracy of knowledge about modes of transmission and means of infection control.

The results of the present study, however, revealed only a slight increase in knowledge. One of the factors that may explain the small increase from the pre to the posttest, is that over half of the shelter directors and service providers had received AIDS training prior to this study (see Item #18, Section A:2). As a consequence, these survey respondents were much more aware of AIDS information than they would have been if the study had been conducted at an earlier time.

At the beginning of this investigation, which began in February, 1988, this researcher was informed by the Homeless Task Force Director that shelter staff

personnel were in need of AIDS education and training. It is obvious from the results that by the time the study was actually conducted, the majority of survey respondents had received some kind of AIDS training. It is unknown to this researcher as to the source and type of training they received. However, only 15 percent answered "Yes" to the question, "Has AIDS training ever been conducted in your shelter?" Nevertheless, it was clearly indicated that more education was needed, especially in regard to ways in which shelter staff could protect themselves.

Another contributing factor to these findings may have been that the majority of the respondents were college graduates. One might conclude that the higher the level of education, the higher the awareness of AIDS related information. However, further research would be needed to substantiate this conclusion.

Prior to the intervention, knowledge was high concerning transmission of AIDS, AIDS risk groups, and prevention measures. Given the relatively high initial pretest scores, knowledge posttest scores were predictably unchanged at the post-intervention assessment.

However, two items in which scores increased slightly deserve discussion.

For example, more than a third of the respondents believed that the AIDS virus could be killed by a ten percent bleach solution. This information gave survey respondents a way in which they could protect themselves when cleaning up after a person thought to have AIDS. As a result, some survey respondents left believing they had more knowledge to protect themselves from getting AIDS. This is important because they were concerned about their own physical safety.

There was also an increase in the number of repondents who believed that the best protection against the spread of AIDS is a proper education. All survey respondents agreed with this statement on the posttest survey (see Item #3, Appendix G).

This is a significant finding as it relates to the importance shelter directors placed on AIDS education. This may be an indication that shelter directors will advocate for AIDS education and training to be offered to shelter staff and/or residents.

In one instance (see Item #24, Appendix G), knowledge was significantly less accurate after the

program than it had been before. This finding may have been due to confusion surrounding the question. Before 1988, the statement that a person can be infected with the AIDS virus but never actually get AIDS itself, was true. However, recent evidence has emerged regarding the increase in the number of people with the virus who have contracted AIDS. As a result of such new evidence, this statement is no longer true. It was uncertain if the information about this issue was made clear during the presentation. Therefore, it is difficult to determine what may have altered the responses to this item.

Overall, it appeared that most shelter workers possessed some knowledge about AIDS prior to the testing, and their knowledge levels increased only slightly after the testing period was concluded. This may have contributed to the lack of significance placed on the knowledge dimension from the pre to posttest period. However, this knowledge could have been acquired through means other than training (i.e., TV, radio, newspaper, brochures).

Fear Dimension

Fear of contagion was defined as being afraid of catching AIDS from working in an area where people with AIDS are thought to reside. Fear of homosexuals (homophobia) was defined as the responses of fear (disgust, anger, discomfort and aversion) that individuals may experience in being around homosexuals.

It was stated in Hypothesis Two that there would be a change in the fear pre and posttest scores indicating a reduction in fear of AIDS. This hypothesis was also not given support by the data. Results had shown that there was very little difference in the overall mean scores in the pre and posttest on the fear dimension.

A primary reason for the small amount of change in scores apparently may be related to the fact that results in the pretest showed that most respondents had little fear of contracting AIDS before the testing occurred. The results of the posttest revealed that only a few more persons were less fearful of contracting the disease.

Prior to the intervention, approximately a fourth of the respondents said they would be afraid to be

around a person in the shelter if they learned that person had AIDS (see Item #25, Appendix G). After the intervention, all respondents said they would not be afraid to be around such a person. This finding differs from Blumenfield's (1987) study in which ten percent of the respondents said they would quit if they had to work with AIDS patients.

Results in the present study were also important as it relates to acceptance of persons with AIDS in a shelter environment. In earlier reports, people were not so willing to let AIDS victims into the shelters (Morris, 1988). It should be noted that the majority of survey respondents held administrative positions and had been affiliated with the homeless for five years.

This is significant because shelter directors usually decide whether or not someone is allowed to enter and/or remain in the shelter. Therefore, it is hoped that the attitudes expressed by the shelter directors result in corresponding behavior. Then, it would be assumed, that this behavior would filter down to shelter workers and volunteers.

There were two questions that addressed the issue of the fear of homosexuality (see Items 30 and 32 in

Appendix G). When asked if they would be afraid to eat in a restaurant where waiters were homosexuals, seventy-five percent of the survey respondents revealed that they would not be afraid. This result was found to be consistent in the posttest scores.

However, when survey respondents were asked if they were more afraid to be around IV drug users than homosexuals, a significant percentage responded in either the strongly agreed or agreed category during the pretest. The scores during the posttest, however, indicated that there was a small decrease in all categories (i.e., including disagree/strongly, disagree). This finding would indicate that respondents had difficulty in expressing how they really felt about this issue.

To further validate this point, thirty percent gave no response to this question during the pretest compared to thirty-seven who did not respond during the posttest. An error in the survey instrument may have contributed to the high number of no responses. Consequently, the results of the this question should be considered with caution.

A review of the literature has addressed the issue of attitudes toward IV drug users versus those toward homosexuals. Feldman and Johnson (1986) have offered reasons why fear of homosexuals may be higher than that of IV drug users. They stated that the stigma against drug users reflects violations of conventional norms governing commitment to work and role obligations. The stigma attached to homosexuality, however, reflects a perceived violation of the societal ground for being human.

The fear of homosexuality (homophobia) was found to be a factor in other studies reviewed (see, for example, Douglas, Kalman, and Kalman, 1985). The literature has suggested that men are usually more homophobic than women. Yet, two studies found the women to be more homophobic than men (Douglas et al., 1985; Wisniewski and Toomey, 1987).

In contrast to the aforementioned studies, the results of the present study revealed that the majority of survey respondents were women who expressed low levels of homophobia. For example, when asked if they thought homosexuals with AIDS got what they deserved, their response was one of disagreement. These results

could be contributed in part to the age of the female survey respondents.

For example, the majority of the respondents were fifty-one years of age and above. This suggests that age may be a determinant with regard to low or high levels of homophobia. Actually, older women may have been more liberal and less fearful of homosexuality.

Most of the survey respondents in this study expressed low levels of fear during the pretest and were even less fearful during the posttest. Fear has been found to effect an individual's receptivity to new information. Leventhal and others (1986) found that the higher the fear, the greater the attitude change. This appears to relevant in this study as well.

Moral Judgment Dimension

Moral judgment was defined as negative preconceived beliefs or attitudes about people with AIDS. An example of a negative attitude was the belief that the person with AIDS deserved the disease.

It was stated in Hypothesis Three that there would be a change in the moral judgment pre and posttest scores indicating a decrease in negative moral judgments toward persons with AIDS. This hypothesis was

not given support by the data. Results showed that there were no significant differences between the means on the pretest and the posttest.

However, a clearer picture regarding positive and negative moral judgments emerged when individual items were reviewed. For example, it was of interest to note that the majority of respondents did not think that homosexuals with AIDS got what they deserve.

Scores on the pretest and posttest remained constant. Scores also remained constant when respondents disagreed that the spread of AIDS in this country is proof that homosexuality should be illegal. In addition, the majority did not think that AIDS was a punishment from God.

Therefore, it appears that the survey respondents do not hold many negative beliefs about homosexuals. It is hoped that this finding indicates that shelter workers will not react negatively toward homosexuals with AIDS who seek shelter services.

When respondents were asked if separate shelters should be available for homeless people with AIDS, the majority agreed or strongly agreed at the pretest period (see Item #26, Appendix G). However, posttest

scores revealed a slight change toward disagreement. It is difficult to determine if shelter directors and service providers agreed that residents needed to be separated for their own protection or segregated for the protection of others.

The most perplexing responses were concerned with AIDS testing. Before and after the intervention, the majority of shelter directors and service providers thought that there should be voluntary AIDS testing in homeless shelters for staff volunteers. When asked if there should be mandatory AIDS testing for the staff volunteers, the majority disagreed.

However, twenty percent of shelter directors and service providers agreed that there should be mandatory testing for residents. Twenty-five percent felt that there should be mandatory testing for staff volunteers as well. However, there may have been some confusion about this question. For example, the issue of AIDS testing may not have been adequately covered in the presentations.

Overall, the responses to the moral judgment items appeared to be fairly positive before and after the intervention. Of course, results could be

attributed to what Kerlinger (1977) referred to as item desirability. This means that one item may be chosen over another simply because it expresses a commonly recognized desirable idea.

The respondents were told by the Homeless Task Force Director, prior to the intervention, that their responses would possibly influence the attitudes of shelter workers in other parts of the country. It was thought that the survey respondents would be motivated to answer according to their personal opinions rather than their perceptions of "correct" responses. Therefore, it is likely that the survey respondents wanted to set a good example for other shelter workers.

The results of this study were not statistically significant. Hypotheses One, Two, and Three were rejected because they were not supported by the data. However, to conclude the analysis of this study on an optimistic note, it might be said that the results were in fact more effective than it appears from the data presented.

For example, when the variances and standard deviations were investigated for the pre and posttests, it was seen that scores were more homogeneous on the

posttest when compared to the pretest. Therefore, there was attitude change on all three dimensions.

When shelter directors and service providers were asked to choose the lifestyles of people who were unacceptable, homosexuals were low on the list. These are positive findings since they indicated that negative moral judgments among this population were lower than expected from people with strong religious backgrounds. It is also an indication that results were harmonious with fear items regarding homosexuals. As stated earlier, the majority of survey respondents did not fear being around homosexuals.

In response to another item, the majority of survey respondents agreed that there should be separate shelters, but that admission should be voluntary. This would seem to indicate that the majority were concerned about the welfare of persons with AIDS.

Limitations of the Study

The present study has several limitations that should be borne in mind when interpreting the results. This study was conducted in the month of January. This is traditionally one of the busiest months for shelter workers since it is one of the coldest months of the

year. It was very difficult for shelter directors and service providers to take off two hours to attend a meeting, especially if their shelters were understaffed. If future studies are conducted with this population, investigators may want to consider the summer months when shelter activity is at a minimum. This would also increase the sample size.

The amount of time needed to conduct a study which includes an educational modality may need to be constructed differently. For example, approximately sixty shelter directors and service providers were in attendance but only forty of these were able to complete both the pre and posttest questionnaires. The rest had to hurry back to their shelters. Consequently, they could not complete the posttest and were lost to the study. This, therefore, reduced the sample considerably.

Because the subject of AIDS was considered to be a sensitive issue by the administrators of the Homeless Task Force, it was suggested that this issue be treated with a great deal of caution. Consequently, attendance and participation was not strongly emphasized in the letter of notification (see Appendix F). Therefore,

participation on the part of all shelter directors and service providers was strictly a voluntary effort when they arrived at the meeting.

The question and answer period occurred after all the posttest was completed. Pertinent information regarding precautionary measures emerged during that time. For example, survey respondents expressed concerns about how to protect oneself while cleaning up vomit or blood from a person with AIDS.

In addition, questions were answered regarding how to use and to mix a bleach solution. It appeared that protective measures were important to those in attendance, especially in light of the fact that almost twenty-five percent said that they worked in shelters where people with AIDS were known to reside.

Here is, yet, another instance in which information was not known prior to the intervention. This information contradicted the original assumptions of the study which were that shelter staff were not aware that people with AIDS were present in the shelter; and, if indeed they knew, they may be too fearful to remain on the job. It became apparent that both assumptions were false. However, the pretest revealed that some

survey respondents knew that persons with AIDS resided in their shelters. Yet, they continued to work as volunteers in these settings.

Results might have revealed even more of a reduction in fear if information regarding protective measures was available before the posttest was administered. Because time was limited, the interest was placed on getting the questionnaires completed before some of the survey respondents had to return to their shelters. Nevertheless, there appeared to be high participation and interest in the subject. Even added comments, though small in number, affirmed the appropriateness and effectiveness of the training. Several examples are listed below:

> "Pastoral counseling needs training like this."
> "Constant training is needed. Thanks for this."
> "Updates as new information is available."
> "We want more training like this."

A fact that needs to be emphasized here is that IV drug use is the primary way in which the AIDS virus is spread among heterosexuals in the United States (Feldman and Johnson, 1986). Yet, it should be made extremely clear that there does not appear to be a great amount of fear of IV drug users. The literature

and studies reviewed pointed out that the greatest amount of fear appears to be of homosexuals.

Conclusion

The problem of homelessness is both formidable and persistent. The ranks of the homeless and homeless people with AIDS continue to grow. AIDS has become the most devastating fatal disease of the twentieth century. There is strong evidence that the disease can not be spread by casual contact. Even so, it is natural that people would continue to show high levels of fear when there are still limited facts available about this disease. The one irrefutable fact, thus far, is that it is almost, always fatal.

On a national level, there is a lack of AIDS training and education in the shelters where people with AIDS are known to reside. There is also a lack of knowledge about AIDS and few guidelines for caring for such persons in shelters. It is apparent that information about this devastating disease must be disseminated to shelters and shelter workers. Unless given adequate knowledge, they may tend to discriminate against homeless AIDS victims due to a fear of catching the disease or ill-conceived moral judgments toward

this population. As research has shown, fear of contagion is a deterrent to treating AIDS patients (Richardson et al., 1987).

In addition to the problems of negative attitudes which may result in rejecting or denying AIDS victims entry to shelters, volunteers may refuse to work in shelters. As a result, the ability to remain operational may be seriously jeopardized. This could happen because of their fear of AIDS and lack of knowledge regarding precautionary measures. It is interesting to note, however, this did not hold true in regard to the population tested in this study.

By the end of this century, it is projected that all Americans will be affected in some way by AIDS. Consequently, Americans will either know someone who has contracted the virus or will have family members or friends with the disease (Ryan, 1986). As more accurate information becomes routinely available, the myths and fears now surrounding the disease will continue to dissipate. At the present time, however, there remains a great need for educational modalities such as the one offered in this study.

When people no longer fear for their personal safety, the immediate response, as with any other life-threatening illness is more likely to be compassionate, supportive, and understanding. In the meantime, it appears that AIDS education and training are the best measures to reduce fear and negative moral judgments against people with AIDS: the population that is the most vulnerable subgroup of the homeless in the twentieth century.

Implications for Social Policy

The need for AIDS education and training is a critical issue for shelter directors. For example, homosexual activity and intravenous drug use continue to occur in the emergency shelters. In addition, workers are unsure as to how to protect themselves because there are no guidelines for precautionary measures. Accurate information about HIV transmission and safety precautions may alter negative attitudes and alleviate fear of catching the disease.

Evidence has suggested that many health care providers are uneasy about the idea of caring for someone with AIDS (Blumenfield et al., 1987; Richardson et al., 1987). These studies point out the

need for education at all levels of the health care system. This author contends that it is equally important for shelter directors to be educated and updated on all AIDS-related issues including prevention strategies.

Of secondary interest in this study was the potential for dissemination. Shelter directors should play major roles in disseminating AIDS information to their staffs to reduce fear and prejudice toward persons with AIDS. It is hoped, therefore, that shelter directors and service providers will carry elements of the educational format back to their shelter staff and volunteers. In addition, this intervention may also spark interest in creating much needed policy regarding the treatment of homeless people with AIDS who seek shelter services.

Policies regarding the treatment of AIDS patients in the shelters are necessary (Hayes, 1987). In addition, education and preventive measures should be implemented that would result in the protection of all shelter workers.

Implications for Social Workers

Many of the shelters offer counseling to their residents. This counseling is frequently provided by social workers. Results from this study indicated that about one quarter of the survey respondents offer counseling to their residents. Shelter directors and service providers have been viewed as change agents. Social workers who serve in that capacity in the city shelters also represent an untapped potential for social change as well. The AIDS crisis challenges social workers to reaffirm traditional values of advocacy, community service, respect for differences, and commitment to social change (Ryan and Rowe, 1988).

The social phenomenon posed by the AIDS epidemic provides a significant opportunity for implementing social change. By virtue of the profession's code of ethics and traditional commitment to serve vulnerable groups, social workers are mandated to respond to the AIDS crisis.

Social workers must ensure that those touched by AIDS can protect their rights to quality of life. If social workers, as professionals, fail to face this crisis, they will dishonor their tradition of social

action and social responsibility and ignore their commitment to social justice (Ryan and Caputo, 1985).

Since AIDS is not going to go away any time soon, there is a need for universities and colleges to include some type of AIDS education in the social work curricula. Atlanta University has set a fine example in this regard. The subject of AIDS has recently been added to the School of Social Work curriculum. There does not appear to be evidence, at this time, that this type of education is occurring on other campuses.

Implications for Future Research

As mentioned earlier, fear has a tremendous impact on service delivery. Although high levels of fear were found among subjects in other studies, the results of this study did not confirm this fact in regard to shelter directors and service providers. The responses of this group indicated that they did not panic because people with AIDS were in the homeless shelters where they worked. Obviously, the level of prejudice was not as high as the author originally thought at the beginning of the research; or other factors overrode their fear and motivated their commitment to their work.

Since other studies have found that fear leads to avoidance, prejudice, and rejection of certain groups and has primarily been the reason for not openly planning for the homeless AIDS population in shelters, the findings of this study hold implications for future research, since the subjects' behavior did not result in panic or ultimate termination of their jobs. How or why did this group differ? Future research should investigate reasons for differences between this group and other groups who provide services to persons with AIDS.

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APPENDIXES

Appendix A

December 15, 1988

Jaquelyn E. Suggs
Atlanta University
School of Social Work
223 Brawley Drive S. W.
Atlanta, GA 30314

_____
Task Force for the Homeless
363 Georgia Avenue S. E.
Atlanta, GA 30312

Dear _____,

This letter will serve as a confirmation of the administrative agreement that you, as Director of The Task Force for the Homeless, and I have made regarding the AIDS educational seminar which will be held during the Shelter Directors' and Shelter Provider's meeting which will be held January 19, 1989 from 12:00 P.M. until 1:30 P.M. at X X X, _____, GA.

As mentioned in our previous conversations, I, Jaquelyn E. Suggs, as researcher, agree to administer pre and post tests in conjunction with the seminar. Further, I also agree to give you a copy of the completed dissertation. I reserve the right to publication.

On the part of the Task Force for the Homeless, you agree to inform all Shelter Directors/Providers of the special agenda for the January 19th meeting.

_____ _____
Signed: Date

_____ _____
Signed: Jaquelyn E. Suggs Date

Thank you for your participation in this endeavor. I look forward to seeing you on the date of the educational seminar.

Sincerely,

Jaquelyn E. Suggs

Appendix B

December 15, 1988

Jaquelyn E. Suggs
Atlanta University
School of Social Work
223 Brawley Drive S. W.
Atlanta, GA 30314

Center for Disease Control
1600 Clifton Road N. E.

Atlanta, GA 30333

Dear _____,

This letter will serve as a confirmation of the administrative agreement that you (on behalf of CDC) and I have made regarding your presentation to shelter directors at the Homeless Task Force meeting which will be held Thursday, January 19, 1989 from 12:00 P.M. until 1:30 P.M.

On the part of _____, you will agree to provide a 20 - 30 minute presentation related to homelessness and AIDS at the above mentioned meeting to be held at at X X X, _____, Decatur, GA.

On the part of Jaquelyn E. Suggs, researcher, I agree to give you a copy of the completed dissertation. I reserve the right to publication.

Signed: Jaquelyn E. Suggs _____ Date

Signed: _____ Date

Thank you for your participation in this endeavor. I look forward to seeing you on the date of your presentation.

Sincerely,

Jaquelyn E. Suggs

Appendix C

December 15, 1988

Jaquelyn E. Suggs
Atlanta University
School of Social Work
223 Brawley Drive S. W.
Atlanta, GA 30314

_____
Associate Director of Education
AID Atlanta
1132 W. Peachtree Street N. W.
Atlanta, GA 30309

Dear _____,

This letter will serve as a confirmation of the administrative agreement that you (on behalf of AID Atlanta) and I have made regarding your presentation to shelter directors at the Homeless Task Force meeting which will be held Thursday, January 19, 1989 from 12:00 P.M. until 1:30 P.M.

On the part of _____, you will agree to provide a 20 - 30 minute presentation related to homelessness and AIDS at the above mentioned meeting to be held at at X X X, _____, Decatur, GA.

On the part of Jaquelyn E. Suggs, researcher, I agree to give you a copy of the completed dissertation. I reserve the right to publication.

_____ _____
Signed: Jaquelyn E. Suggs Date

_____ _____
Signed: Date

Thank you for your participation in this endeavor. I look forward to seeing you on the date of your presentation.

Sincerely,

Jaquelyn E. Suggs

Appendix D

SHELTER DIRECTORS AND SERVICE PROVIDERS' PRETEST SURVEY

Instructions: This survey is designed to be administered to Shelter Directors and Service Providers regarding a variety of issues that center around Acquired Immune Deficiency Syndrome (AIDS). Since there are no right or wrong answers, please check those responses which best describe you and/or your shelter (i.e. Section A or your perceptions/ opinions about AIDS (i.e. Section B).

Please do not identify yourself by name on this survey. In addition, all responses will be held in the strictest of confidence. Since all items are of great importance, kindly take time to respond to each one of them. Your cooperation is greatly appreciated. Thank you so much.

SECTION A: Demographics

1. Age at last birthday

[ ] 20 or less
[ ] 21-25
[ ] 26-30
[ ] 31-35
[ ] 36-40
[ ] 41-45
[ ] 46-50
[ ] 51 and over

2. Sex

[ ] female
[ ] male

3. Race/Ethnic Group

[ ] Black
[ ] White
[ ] Hispanic/Latino
[ ] Asian American
[ ] Native American
[ ] Other

4. Religion

[ ] Catholic
[ ] Protestant
[ ] Jewish
[ ] Non-denominational
[ ] Other
[ ] None

5. Marital Status

[ ] Single
[ ] Married
[ ] Cohabitant
[ ] Divorced
[ ] Widowed
[ ] Separated

6. Education (highest level completed)

[ ] High School
[ ] College
[ ] Masters
[ ] Post Graduate

7. Income (Check personal income only)

[ ] 4,999 and under
[ ] 5,000 -9,999
[ ] 10,000-19,999
[ ] 20,001-29,999
[ ] 30,000-39,999
[ ] 40,000-49,000
[ ] 50,000 and over

8. Number of Children

[ ] None
[ ] One
[ ] Two
[ ] Three
[ ] Four
[ ] Five or more

9. Number of months/years affiliated with a homeless shelter.

[ ] 0-6 months [ ] 6 months-1 year [ ]1-2 years
[ ] 2-3 years [ ] 3-4 years [ ] 5 years or more

10. Current position in shelter

[ ] administrator
[ ] paid staff
[ ] volunteer
[ ] service provider
[ ] other specify _____

11. Length of time in this position.

[ ] 0 - 6 months [ ] 6 months - 1 year
[ ] 1 - 2 years [ ] 2 - 3 years
[ ] 3 - 4 years [ ] 5 years or more

12. Type of shelter you are associated with.

a. [ ] public [ ] private [ ] non-profit

b. [ ] day [ ] night [ ] 24 hour [ ] year round

c. [ ] winter only [ ] transitional

d. [ ] Men [ ] women [ ] children [ ] family

[ ] husbands and wives [ ] women/children
[ ] women and children [ ] men/women/children

e. Shelter capacity _____
(specify)

13. Type of Services your shelter offers (Check all appropriate answers)

[ ] laundry facility
[ ] showers
[ ] meals
[ ] counseling
[ ] child care
[ ] support services
[ ] health screening
[ ] physical health services
[ ] mentally ill agency referrals
[ ] sick rooms
[ ] telephone
[ ] legal services

14. As far as I know, there are people in my shelter with the following conditions (Check all appropriate answers.)

[ ] Tuberculosis
[ ] Upper Respiratory Infections
[ ] AIDS
[ ] Pneumonia
[ ] Malnutrition
[ ] None of the above

15. To your knowledge, has a person with AIDS ever stayed in the shelter you work in? [ ]Yes [ ] No

16. To your knowledge, do homeless residents in the shelter you work in share needles?

17. To your knowledge do homeless residents in the shelter you work in engage in sexual activities on site?

18. Have you ever had any kind of AIDS training prior to today?

19. Has AIDS training ever been conducted in your shelter?

SECTION B: Perceptions/Opinions

Instructions: For each statement, circle the one response that best reflects your perceptions/opinions. Use the following key: SD- Strongly Disagree; D - Disagree; A - Agree; SA - Strongly Agree.

1. People who provide help for someone with AIDS are not personally at risk for getting AIDS. SD D A SA

2. I am not afraid of getting AIDS from casual contact, like shaking hands. SD D A SA

3. The best protection against the spread the AIDS virus is proper education. SD D A SA

4. Children with AIDS should be isolated from other children in the shelters. SD D A SA

5. The AIDS virus can be killed by a 10% bleach solution. SD D A SA

6. People should voluntarily go to sanitariums to protect others from AIDS. SD D A SA

7. Limiting the spread of AIDS is more important than trying to protect the rights of people with AIDS. SD D A SA

8. Homeless people with AIDS should be allowed to stay in shelters with other homeless people. SD D A SA

9. Although I work in a homeless shelter, I am not at risk for getting AIDS or the AIDS virus. SD D A SA

10. A person who has the AIDS virus is worse off than a person who is known to have AIDS. SD D A SA

11. I think homosexuals with AIDS get what they deserve. SD D A SA

12. There is now a test for the AIDS virus. SD D A SA

13. There should be voluntary AIDS testing in homeless shelters for staff volunteers. SD D A SA

14. People with AIDS should not be allowed to handle food if they are restaurant workers. SD D A SA

15. Only people who are homosexual/ bisexual, IV drug users, prostitutes, and hemophiliacs can be infected with the AIDS virus. SD D A SA

16. There should be mandatory AIDS testing in homeless shelters for residents. SD D A SA

17. The thought of being around someone who has AIDS does not bother me. SD D A SA

18. I would allow my children to play with children who have AIDS. SD D A SA

19. There should be mandatory AIDS testing in homeless shelters for staff and volunteers. SD D A SA

20. The spread of AIDS in the United States is proof that homosexual behavior should be illegal. SD D A SA

21. I would quit my job before I would work with someone who has AIDS or the AIDS virus. SD D A SA

22. There should be voluntary drug testing for shelter residents. SD D A SA

23. Insurance companies should not be allowed to cancel insurance policies for AIDS-related reasons. SD D A SA

24. AIDS is a disease caused by a virus that can damage the brain. SD D A SA

25. If I learned that someone in the shelter I work in had AIDS, I would be afraid to be around him/her. SD D A SA

26. Separate shelters should be available for homeless with AIDS. SD D A SA

27. I do not think AIDS is a punishment for immoral behavior. SD D A SA

28. Not sharing needles is one recommended AIDS prevention measure for IV drug users. SD D A SA

29. AIDS is a disease caused by a virus that can weaken the immune system. SD D A SA

30. I would be afraid to eat in a restaurant where waiters were homosexuals. SD D A SA

31. A person can be infected with the AIDS virus but never get AIDS. SD D A SA

32. I am more afraid to be around drug users than homosexuals. SD D A SA

33. I am not afraid of getting AIDS from casual contact (such as hugging). SD D A SA

34. You can't tell by looking that someone has AIDS. SD D A SA

35. I think IV drug users with AIDS get what they deserve. SD D A SA

Appendix E

SHELTER DIRECTORS AND SERVICE PROVIDERS POSTTEST SURVEY

Instructions: For each statement, circle the one response that best reflects your perceptions/opinions. Use the following key: SD-Strongly Disagree; D-Disagree; A-Agree; SA-Strongly Agree.

1. People who provide help for someone with AIDS are not personally at risk for getting AIDS. SD D A SA

2. I am not afraid of getting AIDS from casual contact, like shaking hands. SD D A SA

3. The best protection against the spread the AIDS virus is proper education. SD D A SA

4. Children with AIDS should be isolated from other children in the shelters. SD D A SA

5. The AIDS virus can be killed by a 10% bleach solution. SD D A SA

6. People should voluntarily go to sanitariums to protect others from AIDS. SD D A SA

7. Limiting the spread of AIDS is more important than trying to protect the rights of people with AIDS. SD D A SA

8. Homeless people with AIDS should be allowed to stay in shelters with other homeless people. SD D A SA

9. Although I work in a homeless shelter, I am not at risk for getting AIDS or the AIDS virus. SD D A SA

10. A person who has the AIDS virus is worse off than a person who is known to have AIDS. SD D A SA

11. I think homosexuals with AIDS get what they deserve. SD D A SA

12. There is now a test for the AIDS virus. SD D A SA

13. There should be voluntary AIDS testing in homeless shelters for staff volunteers. SD D A SA

14. People with AIDS should not be allowed to handle food if they are restaurant workers. SD D A SA

15. Only people who are homosexual/ bisexual, IV drug users, prostitutes, and hemophiliacs can be infected with the AIDS virus. SD D A SA

16. There should be mandatory AIDS testing in homeless shelters for residents. SD D A SA

17. The thought of being around someone who has AIDS does not bother me. SD D A SA

18. I would allow my children to play with children who have AIDS. SD D A SA

19. There should be mandatory AIDS testing in homeless shelters for staff and volunteers. SD D A SA

20. The spread of AIDS in the United States is proof that homosexual behavior should be illegal. SD D A SA

21. I would quit my job before I would work with someone who has AIDS or the AIDS virus. SD D A SA

22. There should be voluntary drug testing for shelter residents. SD D A SA

23. Insurance companies should not be allowed to cancel insurance policies for AIDS-related reasons. SD D A SA

24. AIDS is a disease caused by a virus that can damage the brain. SD D A SA

25. If I learned that someone in the shelter I work in had AIDS, I would be afraid to be around him/her. SD D A SA

26. Separate shelters should be available for homeless with AIDS. SD D A SA

27. I do not think AIDS is a punishment for immoral behavior. SD D A SA

28. Not sharing needles is one recommended AIDS prevention measure for IV drug users. SD D A SA

29. AIDS is a disease caused by a virus that can weaken the immune system. SD D A SA

30. I would be afraid to eat in a restaurant where waiters were homosexuals. SD D A SA

31. A person can be infected with the AIDS virus but never get AIDS. SD D A SA

32. I am more afraid to be around drug users than homosexuals. SD D A SA

33. I am not afraid of getting AIDS from casual contact (such as hugging). SD D A SA

34. You can't tell by looking that someone has AIDS. SD D A SA

35. I think IV drug users with AIDS get what they deserve. SD D A SA

36. Comments

List any future training or education you feel you need regarding AIDS.

_____

_____

_____

Appendix F

TASK FORCE FOR THE HOMELESS

363 Georgia Avenue, SE (2nd Floor)
Atlanta, Georgia 30312
(404) 589-9495

December 26, 1988

To: All Shelter Directors and Service Providers

From: Anita L, Beaty
Jackie Suggs, Atlanta University

It's finally time to talk about something we have all been avoiding: AIDS and homelessness! It's time to examine our attitudes and our need for education about the risks and fear involved in working with homeless people.

It is clear that we can't solve a problem until we have identified it, so we will take the opportunity at the next Shelter Providers' meeting, January 19, to confront the issue.

Don't miss this opportunity to join your peers in identifying the issues and confronting our attitudes toward the issues.

The meeting will be held at Shearith Israel, home of a night shelter for single women, at 12:00 noon on January 19, 1989. Mrs. Helen Spiegel will be our hostess for this important meeting.

Some of the questions we will confront are:

Do you have concerns about the people who visit your shelter? Have you any idea about referral agencies for support with this issue? Is the issue of insurance a consideration?

There is no shortage of information in the medical and scientific communities; but we have not accessed the information for our own network. This is the beginning of an effort to do just that.

Let's be very candid in addressing our fears and attitudes together!

The session will be videotaped for use with other groups.

Appendix G

Survey Respondents' Knowledge Pre and Posttest Change Scores.

Item 3: The best protection against the spread the AIDS virus is proper education.

	Pre	Post
Strongly disagree	2.5	0
Disagree	2.5	0
Agree	42.5	42.5
Strongly agree	52.5	57.5
No response	0	0
Total	100.0	100.0

Item 5: The AIDS virus can be killed by a 10% bleach solution.

Strongly disagree	30	7.5
Disagree	22.5	10
Agree	27.5	37.5
Strongly agree	17.5	42.5
No response	2.5	2.5
Total	100.0	100.0

Item 10: A person who has the AIDS virus is worse off than a person who is known to have AIDS.

Strongly disagree	37.5	35
Disagree	47.5	40
Agree	12.5	17.5
Strongly agree	0	5
No response	2.5	2.5
Total	100.0	100.0

Item 12: There is now a test for the AIDS virus.

	Pre	Post
Strongly disagree	15	25
Disagree	25	10
Agree	35	35
Strongly agree	25	30
No response	0	0
Total	100.0	100.0

Item 15: Only people who are homosexual/bisexual, IV drug users, prostitutes, and hemophiliacs can be infected with the AIDS virus.

Strongly disagree	60	60
Disagree	17.5	27.5
Agree	12.5	5
Strongly agree	7.5	7.5
No response	2.5	0
Total	100.0	100.0

Item 24: AIDS is a disease caused by a virus that can damage the brain.

Strongly disagree	10	10
Disagree	42.5	45
Agree	25	22.5
Strongly agree	22.5	20
No response	0	2.5
Total	100.0	100.0

Item 28: Not sharing needles is one recommended AIDS prevention measure for IV drug users.

Strongly disagree	5	10
Disagree	5	0
Agree	22.5	32.5
Strongly agree	65	55
No response	2.5	2.5
Total	100.0	100.0

Item 29: AIDS is a disease caused by a virus that can weaken the immune system.

	Pre	Post
Strongly disagree	0	5
Disagree	5	10
Agree	20	25
Strongly agree	70	55
No response	5	5
Total	100.0	100.0

Item 31: A person can be infected with the AIDS virus but never actually get AIDS itself.

Strongly disagree	7.5	15
Disagree	15	25
Agree	50	47.5
Strongly agree	20	12.5
No response	7.5	0
Total	100.0	100.0

Item 34: You can't tell by looking that someone has AIDS.

Strongly disagree	10	7.5
Disagree	2.5	5
Agree	15	7.5
Strongly agree	25	40
No response	47.5	40
Total	100.0	100.0

Survey Respondents' Fear Pre and Posttest Change Scores

Item 1: People who provide help for someone with AIDS are not personally at risk for getting AIDS.

	Pre	Post
Strongly disagree	7.5	5
Disagree	22.5	7.5
Agree	50	45
Strongly agree	20	42.5
No response	0	0
Total	100.0	100.0

Item 2: I am not afraid of getting AIDS from casual contact, like shaking hands.

Strongly disagree	5	2.5
Disagree	7.5	0
Agree	32.5	37.5
Strongly agree	55	60
No response	0	0
Total	100.0	100.0

Item 9: Although I work in a homeless shelter, I am not at risk for contracting AIDS or the AIDS virus.

Strongly disagree	2.5	2.5
Disagree	22.5	12.5
Agree	50	50
Strongly agree	17.5	35
No response	7.5	0
Total	100.0	100.0

Item 17: The thought of being around someone who has AIDS does not bother me.

	Pre	Post
Strongly disagree	2.5	0
Disagree	20	15
Agree	52.5	52.5
Strongly agree	25	30
No response	0	2.5
Total	100.0	100.0

Item 18: I would allow my children to play with children who have AIDS.

Strongly disagree	0	2.5
Disagree	17.5	5
Agree	25	32.5
Strongly agree	20	20
No response	37.5	40
Total	100.0	100.0

Item 21: I would quit my job before I would work with someone who has AIDS or the AIDS virus.

Strongly disagree	50	55
Disagree	35	27.5
Agree	10	7.5
Strongly agree	5	7.5
No response	0	2.5
Total	100.0	100.0

Item 25: If I learned that someone in the shelter I work in has AIDS, I would be afraid to be around that person.

Strongly disagree	35	47.5
Disagree	37.5	52.5
Agree	22.5	0
Strongly agree	0	0
No response	5	0
Total	100.0	100.0

Item 30: I would be afraid to eat in a restaurant where waiters were homosexuals.

	Pre	Post
Strongly disagree	47.5	45
Disagree	27.5	35
Agree	15	12.5
Strongly agree	2.5	5
No response	7.5	2.5
Total	100.0	100.0

Item 32: I am more afraid to be around drug users than homosexuals.

Strongly disagree	12.5	12.5
Disagree	17.5	15
Agree	22.5	22.5
Strongly agree	17.5	12.5
No response	30	37.5
Total	100.0	100.0

Item 33: I am not afraid of getting AIDS from causal contact, like hugging.

Strongly disagree	5	2.5
Disagree	5	2.5
Agree	27.5	35
Strongly agree	55	55
No response	7.5	5
Total	100.0	100.0

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Item 4: Children with AIDS should be isolated from other children in the shelters.

	Pre	Post
Strongly disagree	15	27.5
Disagree	47.5	47.5
Agree	22.5	17.5
Strongly agree	12.5	7.5
No response	2.5	0
Total	100.0	100.0

Item 6: People should voluntarily go to sanitariums to protect others from AIDS.

Strongly disagree	47.5	50
Disagree	30	32.5
Agree	10	15
Strongly agree	5	0
No response	7.5	2.5
Total	100.0	100.0

Item 7: Limiting the spread of AIDS is more important than trying to protect the rights of people with AIDS.

Strongly disagree	35	30
Disagree	37.5	37.5
Agree	17.5	27.5
Strongly agree	7.5	5
No response	2.5	0
Total	100.0	100.0

Item 8: Homeless people with AIDS should be allowed to stay in shelters with other homeless people.

	Pre	Post
Strongly disagree	12.5	2.5
Disagree	25	10
Agree	47.5	50
Strongly agree	15	35
No response		2.5
Total	100.0	100.0

Item 11: I think homosexuals with AIDS get what they deserve.

Strongly disagree	52.5	55
Disagree	10	7.5
Agree	5	7.5
Strongly agree	0	2.5
No response	32.5	27.5
Total	100.0	100.0

Item 13: There should be voluntary AIDS testing in homeless shelters for staff volunteers.

Strongly disagree	22.5	17.5
Disagree	17.5	22.5
Agree	50	47.5
Strongly agree	5	10
No response	5	2.5
Total	100.0	100.0

Item 14: People with AIDS should not be allowed to handle food in restaurants.

Strongly disagree	12.5	32.5
Disagree	42.5	50
Agree	37.5	12.5
Strongly agree	5	2.5
No response	2.5	2.5
Total	100.0	100.0

Item 16: There should be mandatory AIDS testing in homeless shelters for residents.

	Pre	Post
Strongly disagree	45	42.5
Disagree	30	25
Agree	10	30
Strongly agree	10	0
No response	5	2.5
Total	100.0	100.0

Item 19: There should be mandatory AIDS testing for shelter staff and volunteers.

Strongly disagree	35	37.5
Disagree	35	30
Agree	22.5	20
Strongly agree	2.5	5
No response	5	7.5
Total	100.0	100.0

Item 20: The spread of AIDS in this country is proof that homosexuality should be illegal.

Strongly disagree	57.5	60
Disagree	22.5	20
Agree	10	17.5
Strongly agree	7.5	2.5
No response	2.5	
Total	100.0	100.0

Item 22: There should be voluntary drug testing for shelter residents.

Strongly disagree	17.5	27.5
Disagree	15	12.5
Agree	55	42.5
Strongly agree	12.5	12.5
No response	0	5
Total	100.0	100.0

Item 23: Insurance companies should not be allowed to cancel insurance policies for AIDS-related reasons.

	Pre	Post
Strongly disagree	17.5	10
Disagree	12.5	2.5
Agree	25	30
Strongly agree	40	50
No response	5	7.5
Total	100.0	100.0

Item 26: Separate shelters should be available for homeless with AIDS.

Strongly disagree	12.5	15
Disagree	22.5	37.5
Agree	50	35
Strongly agree	10	12.5
No response	5	0
Total	100.0	100.0

Item 27: I do not think AIDS is a punishment for immoral behavior.

Strongly disagree	17.5	10
Disagree	10	2.5
Agree	27.5	25
Strongly agree	40	60
No response	5	2.5
Total	100.0	100.0

Item 35: I think IV drug users with AIDS get what they deserve.

Strongly disagree	47.5	50
Disagree	32.5	22.5
Agree	15	12.5
Strongly agree	2.5	10
No response	2.5	5
Total	100.0	100.0